Metro South Health

Quality healthcare every day

Metro South Health and Hospital Service

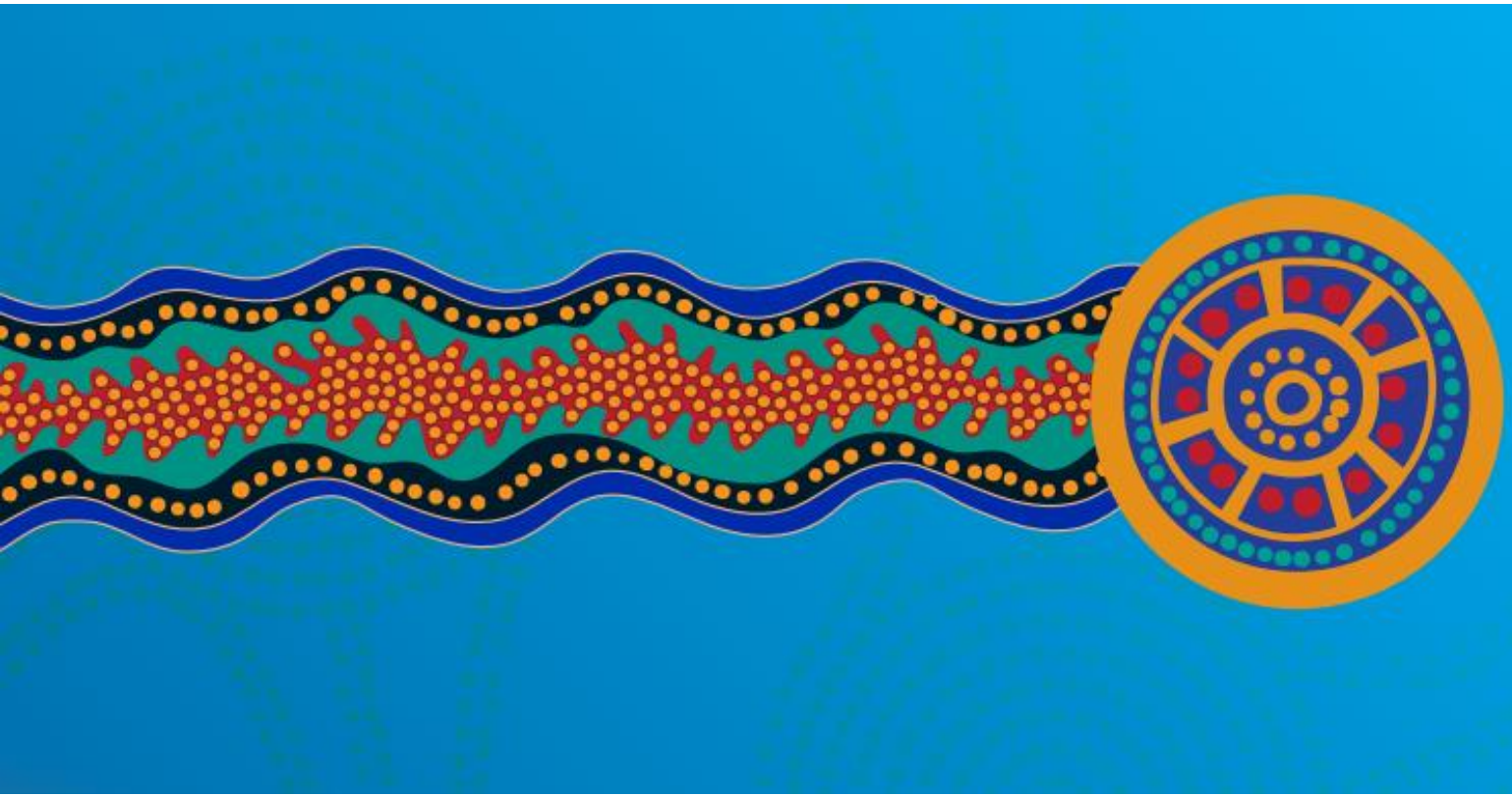
GP Gynaecology Education Day

20th June 2026

ICARE² values

INTEGRITY COMPASSION ACCOUNTABILITY RESPECT ENGAGEMENT EXCELLENCE

Queensland Government



Metro South Health acknowledges the Yugambeh, Quandamooka, Jaggera, Ugarapul and Turrbal, the traditional Custodians of the land on which we meet today, recognising their shared country, their continuing connection to the lands, the waters, and communities.

We pay respects to the Elders past, present, and emerging and extend that respect to Aboriginal and Torres Strait Islander peoples here today.

In our education today, we recognise the importance of recognising those people who do not identify as women when discussing our care for gynaecological and reproductive health issues. We respectfully acknowledge that some people may not identify as 'female' or as having a lived experience of 'womanhood' but have been assigned as female at birth.

Introducing today's team …..

- Facilitator: Dr Kim Nolan , GP - GPLO Maternity
- Natasha Grieg, Acting GPLO Midwife Manager

Acknowledgments

- Metro South Health and Hospital Service
- Maternity Services at Logan/Beaudesert/Redland Hospitals for their clinical input and support
- OUR PRESENTERS TODAY:
    - Dr Hasthika Ellepola
    - Dr Scott Walker
    - Melanie Walkenhorst
    - Elisha Conley, Surgiflow Nurse Manager

- Yourselves
- And a big THANK YOU to our sponsor today – Bayer Pharmaceuticals

Prereading:

Cervical Cancer Screening - Community HealthPathways Brisbane South

Female Genital Mutilation/Cutting (FGM/C) - Community HealthPathways Brisbane South

Abnormal Vaginal Bleeding - Community HealthPathways Brisbane South

Urinary Incontinence in Women - Community HealthPathways Brisbane South

Prolapse - Community HealthPathways Brisbane South

Vaginal Pessaries - Community HealthPathways Brisbane South

House keeping

- **Raise your hand** if you want to contribute to the discussion or to ask any questions.
- **Phones on silent please**.

Some slides have QR codes that you are welcome to make use of to access resources – please be mindful of avoiding obstruction of the view of others.

We would also like to take some photographs to use in the O & G Department, and to illustrate GP participation in these events. Please speak to us if you do not wish to have your photograph taken.

Session 1

Time	Session name	Presenter	Delivery
8:00 am	Welcome, Housekeeping, learning objectives.	Dr Kim Nolan	GP Facilitator
8:10 am – 8:40 am	Task 1 Breakout groups – Case Discussion	Breakout	Facilitated groups
8:40 am	Case Discussion – Abnormal Cervical Screening Test Follow Up	Group Spokesperson Dr Scott Walker	Facilitated groups Power Point Presentation & Forum Discussion
9:10am	Case Discussion – Heavy Menstrual Bleeding	Group Spokesperson Dr Hasthika Ellepola	Facilitated groups Power Point Presentation & Forum Discussion
9:40 am	Same Day Gynaecology Surgery	Elisha Conley Dr Hasthika Ellepola	Power Point Presentation & Forum Discussion
10:00 am	Morning Tea	ALL	

Session 2

Time	Session name	Presenter	Delivery
10:30 am	Case Discussions – Pelvic Floor Prolapse and Urinary Incontinence	Group Spokesperson Dr Hasthika Ellepola	Facilitated groups Power Point Presentation & Forum Discussion
10:50 am	Physiotherapy Management of Prolapse, Urinary and Faecal incontinence; Physiotherapy Pelvic Health Service in MSHHS	Melanie Walkenhorst	Power Point Presentation & Forum Discussion
11:15 – 12:30pm	Hands-On Practical Demonstrations - Vaginal Pessaries - Implanon Insertion - IUD Insertion Simulator - Pipelle Biopsy Demo - Novasure/Myosure Demo	Breakout Group Rotations	Facilitated groups Power Point Presentation & Forum Discussion
12:30 pm	Wrap Up CPD Discussion	Dr Kim Nolan ALL	ALL

Learning Objectives

- Improve knowledge of common gynaecological conditions and best practice primary care assessment and management.
- Improve knowledge in the recognition of serious, less common conditions with development of skills to recognise red flags and refer as appropriate.
- Understanding of MSHHS requirements for Gynaecology referrals, and recommended pathways.
- Improved knowledge of guidelines and resources that can assist GPs in care of their gynaecology patients.

Green Group – Task

- Zuri is aged 32 years, who attends to have a “smear test”.
- He friend told her she was able to collect it herself – is that something you offer?
- She has a new regular partner and may try to fall pregnant in next few years.
- PHX genital HSV but no recurrences for 18 months.
- Her history includes CIN 3 when in her mid 20’s – she had surgery at that time and attended for follow up for a few years but then lapsed in going back to the hospital in Sydney. No tests since then.
- Zuri moved to Australia from Kenya at age 17 years.

She has a 15 min appointment - Outline your approach

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Follow Up Abnormal Cervical Screening Test

Dr Scott Walker
Staff Specialist - Obstetrics and Gynaecology
Logan Hospital

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TRUE FACTSHEET:
CULTURALLY RESPONSIVE HEALTH

Female genital mutilation/ cutting/circumcision (FGM/C) for Health Professionals

true
relationships & reproductive health

This resource aims to address cultural awareness and is not a clinical guideline. This resource has been developed with the Culturally Responsive Health Advisory Group and community representatives.

Language

Female genital mutilation/cutting/ circumcision (FGM/C) is used to acknowledge differing perspectives.

The World Health Organization (WHO) defines female genital mutilation (FGM) as

comprising all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons.[i]

This language emphasises human rights, particularly children's and women's rights.

Members of cultural communities involved with this practice do not traditionally use the term FGM. The practice may be known as circumcision or traditional cutting. For some women[ii] and communities, the term mutilation may be offensive or imply that the practice is carried out to cause harm. It can also cast a negative association on the bodies of women who experienced the procedure.[iii]

Where and why is FGM/C practiced?

It is unknown exactly how many girls and women worldwide are living with FGM/C. WHO estimates that at least 200 million girls and women have undergone FGM/C procedures in 30 countries.[iv] A 2019 study by the Australian Institute of Health and Welfare estimated that 53,000, or 4.3 per 1,000, girls and women girls born elsewhere but living in Australia have experienced FGM/C.[v]

FGM/C is highly concentrated in a band of countries stretching from the Atlantic coast to East Africa, in some areas of the Middle East, and in some countries in South East Asia (for prevalence rates see footnote v). In some countries, including Somalia, Guinea and Djibouti, FGM/C is very common, while in other countries it is practiced by a minority of people. For this reason, it is difficult to make assumptions about a woman's experience based on her home country.

Over the past three decades, the prevalence of FGM/C has declined because of changing attitudes.[vi] Representative data on women's attitudes shows that the majority of women in most countries in Africa and the Middle East think it should no longer be performed in their context.[vii] A 2015 literature review study of men from countries where FGM/C occurs found that many men did not feel strong support for the ongoing practice, and many wanted to abandon the practice because of the negative implications for women.[viii]

For communities that practice FGM/C, it is performed as part of historic and cultural tradition. FGM/C is a cultural rather than a religious practice and is not endorsed by Christianity, Judaism, or Islam.[ix] It is important to recognise that communities may practice FGM/C with an intention to increase girls' future opportunities, including marriage. Reasons vary: in some communities it constitutes a rite of passage to adulthood and is performed to confer a sense of ethnic and gender identity. FGM/C may be practiced because of beliefs that it preserves virginity and/or modesty; beliefs that it will make women more easily sexually satisfied; for perceived hygiene and aesthetic reasons, to increase a bride's dowry; or to control women's sexuality. In many contexts, social acceptance is a primary reason for continuing the practice and there may stigma if FGM/C is not practiced.

World Health Organization (WHO) defines female genital mutilation (FGM) as comprising all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons.

FGM needs to be asked about (Female genital mutilation/cutting/circumcision (FGM/C) for Health Professionals - Cultural awareness Fact Sheet from "True – relationships and reproductive health)

> Girls and women [affected by FGM/C] need high quality, empathetic and appropriate health care to meet their specific needs.
>
> WHO 2018[x]

Female Genital Mutilation/Cutting/Circumcision

Percentage of women and girls aged 15 to 49 years who have undergone FGM/C

90-99%	80-89%	70-79%	60%-69%	40-49%
Somalia, Guinea, Djibouti	Mali, Egypt, Sudan, Sierra Leone, Eritrea	Burkina Faso, Gambia	Mauritania, Ethiopia	Indonesia, Guinea-Bissau, Liberia

30-39%	20-29%	10-19%	1-9%
Chad, Côte d'Ivoire	Senegal, Central African Republic, Kenya	Yemen, Nigeria, Maldives, United Republic of Tanzania	Benin, Iraq, Ghana, Togo, Niger, Cameroon [2]

Short term

- Severe pain
- Excessive bleeding
- Shock
- Psychological trauma
- Infection - recurrent infections can impact on a woman's ability to enjoy life and fully participate in her family and community
- Urinary retention
- Death

Long term

- Reproductive tract infection
- Complication during pregnancy and childbirth - fistulas can result from a prolonged labour when a (Type III) circumcised woman cannot deliver the baby.
- Infertility
- Painful periods
- Psychological issues e.g. depression/PTSD
- Fear and avoidance of cervical screening
- Difficulty in undergoing cervical screening
- Scarring
- Sexual complications

How to ask about FGC/M

All women who may be affected by FGC/M should be asked about it. Here are some sample questions:

1. **Which country were you born in?**
   Cross check the woman's country of origin with the prevalence of practice in that country.
2. **I understand that traditional genital cutting is a common practice in your country. Would you mind if I asked you if you have been circumcised or have had traditional cutting? It is important for me to know before I examine you.**
   Some women don't know if they have been circumcised and when it may have occurred.
3. **Have you had a Cervical Screening Test before?**
   Some women may know of this as a Pap smear or Pap test.
4. **Have you ever had an uncomfortable cervical screening experience in the past? If so, it may be helpful to let me know why this was difficult for you?**
   Negative past experience is a known barrier to cervical screening.
5. **To help inform your decision about how best to complete a Cervical Screening Test, I may need to look at you first.**
   You will need to assess the level of difficulty performing the test; if you are in doubt please do not continue and refer the woman to a specialist hospital.

Female genital mutilation/cutting (FGM/C) and cervical screening: A guide for healthcare providers

Human Papilloma Virus

- > 40 anogenital HPV types
- 14 classified ‘high risk’ or oncogenic – detected on CST
- Most HPV infections cleared within 12-24/12; up to 10% persist
- 98% of people infected with genital HPV will clear virus naturally within 5 years, 90% within 2 years.
- Persistent infection with oncogenic HPV types is generally subclinical but can result long term in development of a range of anogenital tumours including cancers of the cervix, anus, penis, vulva and vagina.
- Also associated with squamous cell carcinomas of head and neck, particularly oropharyngeal cancers
- HPV infection is necessary, but not sufficient for development of cervical cancer. Other contributing risks:
  - Smoking
  - Multiparity (> 5 full term pregnancies)
  - Early age first pregnancy
  - OCP use
  - Immune deficiency (e.g., HIV infection)
- Although majority of HPV positive women infected within few years of sexual debut, cervical cancer incidence peaks at about age 45 yrs; i.e., slow progression

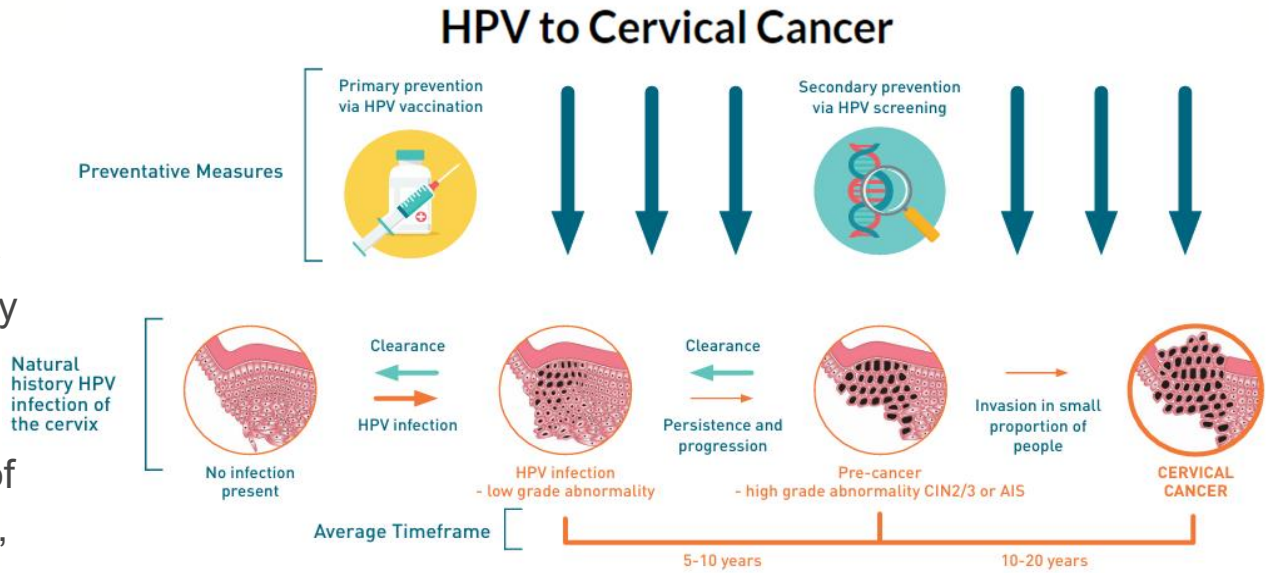
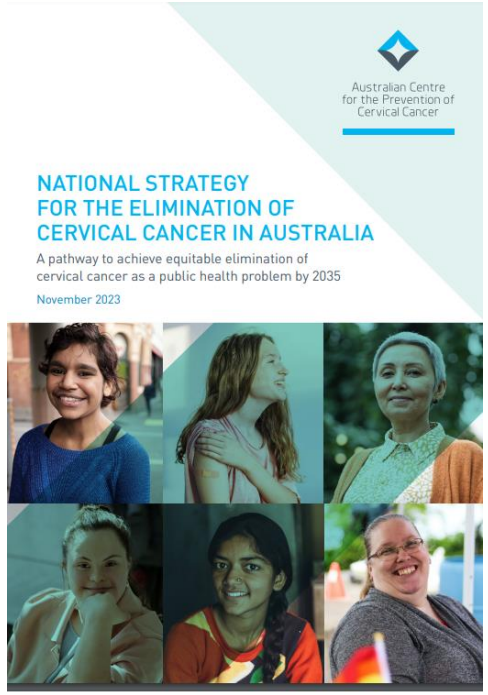


Image from: VCS Pathology, National Cervical Screening Program Guidelines, HPV and Cervical Screening. Available from: https://acpcc.org.au/wp-content/uploads/2024/05/24016_VCS.HPV-AND-CERVICAL-SCREENING.CD04.pdf

https://www.cancer.org.au/clinical-guidelines/cervical-cancer/cervical-cancer-screening/the-rationale-for-primary-hpv-screening

National Strategy for the Elimination of Cervical Cancer

- Outlines Australia's commitment to achieve equitable elimination of cervical cancer by 2035 & the objectives/actions needed to achieve this goal.
- Aligned with WHO's goal - agreed elimination threshold is < 4 cases/100,000 women in **all** countries worldwide within next century (2019 in Aust – 6.4 new cases /100, 000 women)
- 14th most common cancer in women/people with a cervix in Australia (17th most common cause of cancer death among this group). Double that rate in Aboriginal and Torres Strait Islander females.
- To put countries on path to elimination, **WHO set 3 targets** that each country should achieve by 2030 and then maintain & improve upon: **90:70:90** targets.
- * Extended AUSTRALIAN Targets by 2030 in green
- Targets set for all countries worldwide, **regardless of current income, HPV vaccination & cervical screening status.**
- WHO targets*
  - **90%** of girls (& boys) to be fully HPV vaccinated by 15 years of age
  - **70%** of women to be screened by 35 & again by 45 years of age using a high precision test i.e., an HPV polymerase chain reaction (PCR) test (extending the 70% screening target to 5-yearly participation for all eligible 25- to 74-year-olds, rather than twice in a lifetime)
  - **90%** (95%) of women identified with cervical disease receive treatment for pre-cancerous lesions or management of invasive cancer.

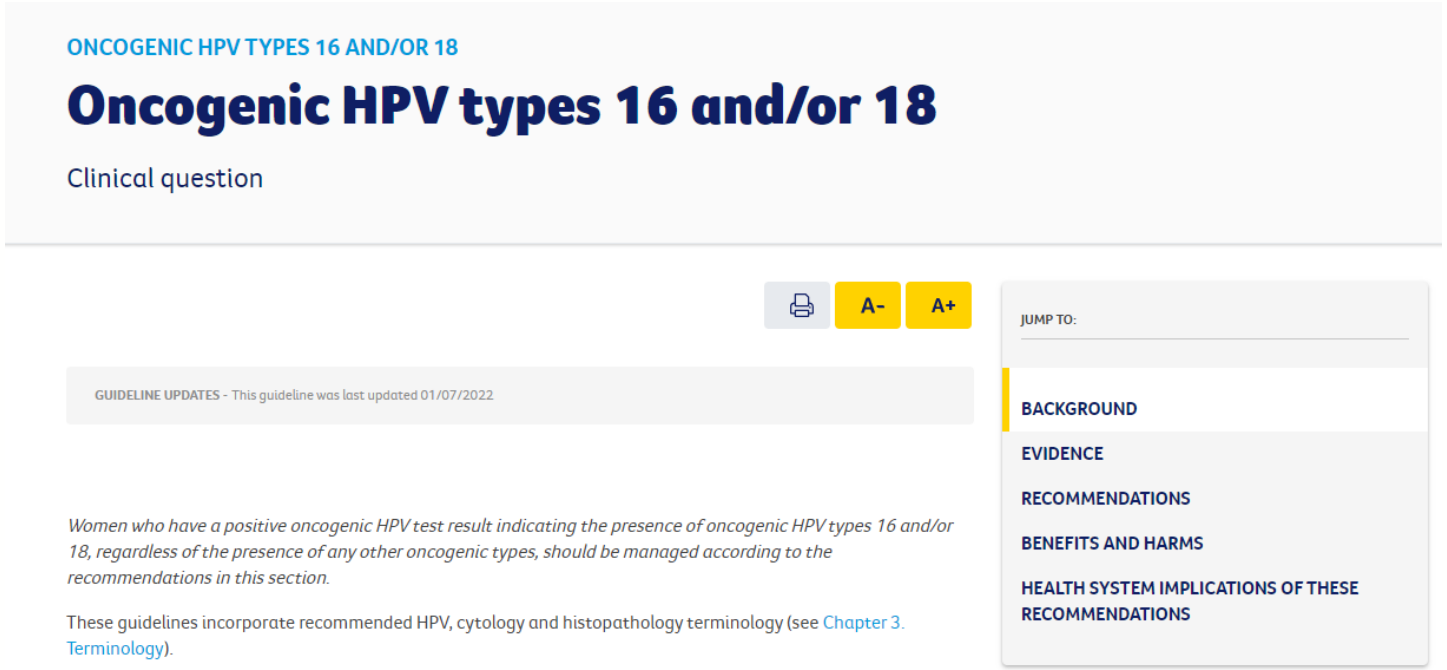


https://www.health.gov.au/sites/default/files/2023-11/national-strategy-for-the-elimination-of-cervical-cancer-in-australia.pdf

AUSTRALIA IS ON TRACK TO BE THE FIRST COUNTRY IN THE WORLD TO ELIMINATE CERVICAL CANCER AS A PUBLIC HEALTH PROBLEM POTENTIALLY AS EARLY AS 2028

CLINICAL GUIDELINES SITEMAP

Cancer Council Australia



- Australia well into ninth year of renewed National Cervical Screening Program – primary HPV testing with cytology as triage (5-yearly as routine)
- Worldwide, oncogenic HPV types 16/18 are detected in approximately 70% of cervical cancers.
- HPV 16 is the most carcinogenic, accounting for about 55–60% of cervical cancers
- HPV 18 accounts for a further 10–15% of cervical cancers (same frequency as HPV 16 in cervical adenocarcinomas)
- Preliminary results from a recent Australian consecutive case series found that HPV types 16 and 18 were detected in 52.3% and 19.4% of cervical cancers, respectively.

https://www.cancer.org.au/clinical-guidelines/cervical-cancer/cervical-cancer-screening/management-of-oncogenic-hpv-test-results/oncogenic-hpv-types-16-and-or-18

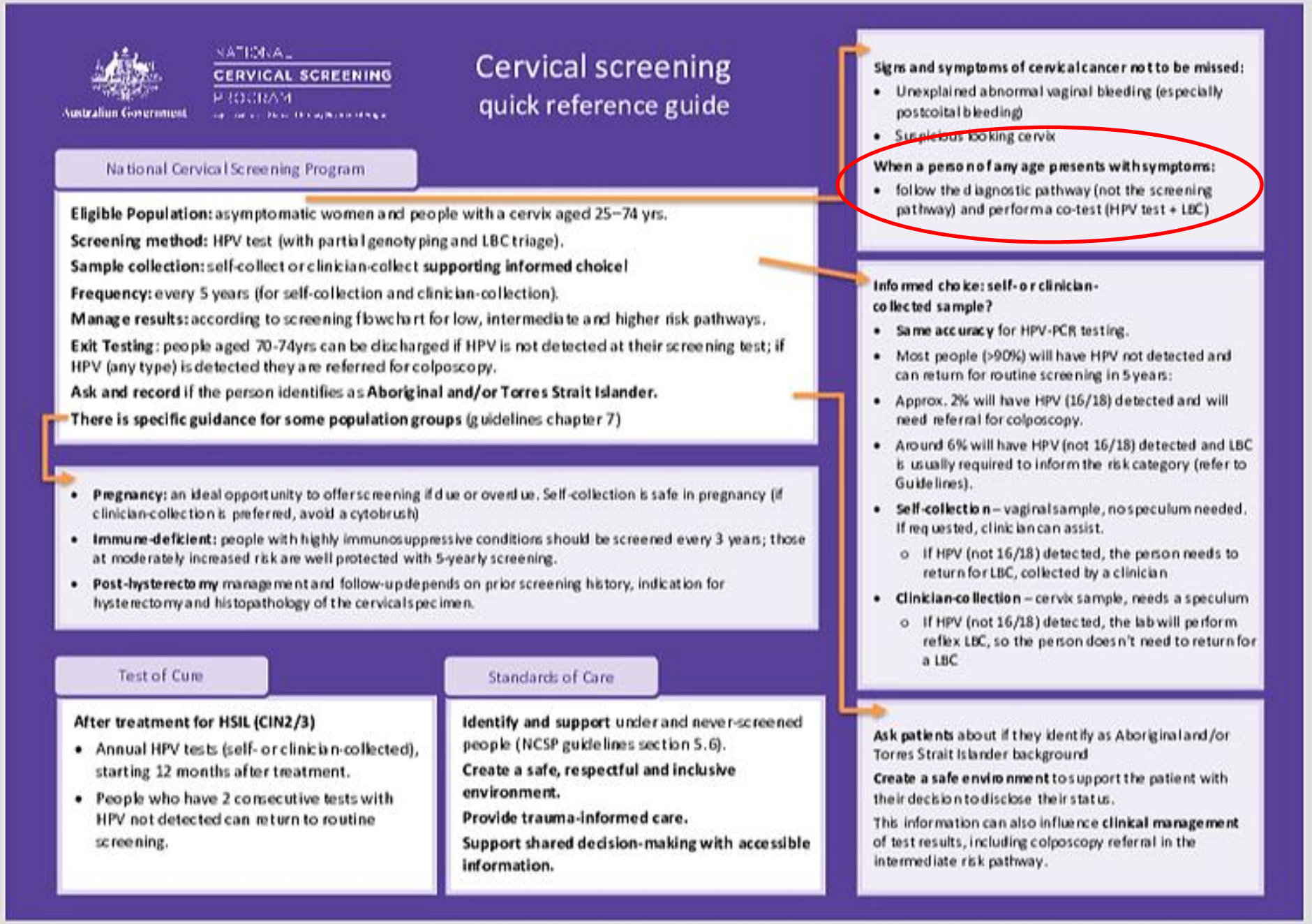
Cervical Screening Tests – why the change to 5 years?

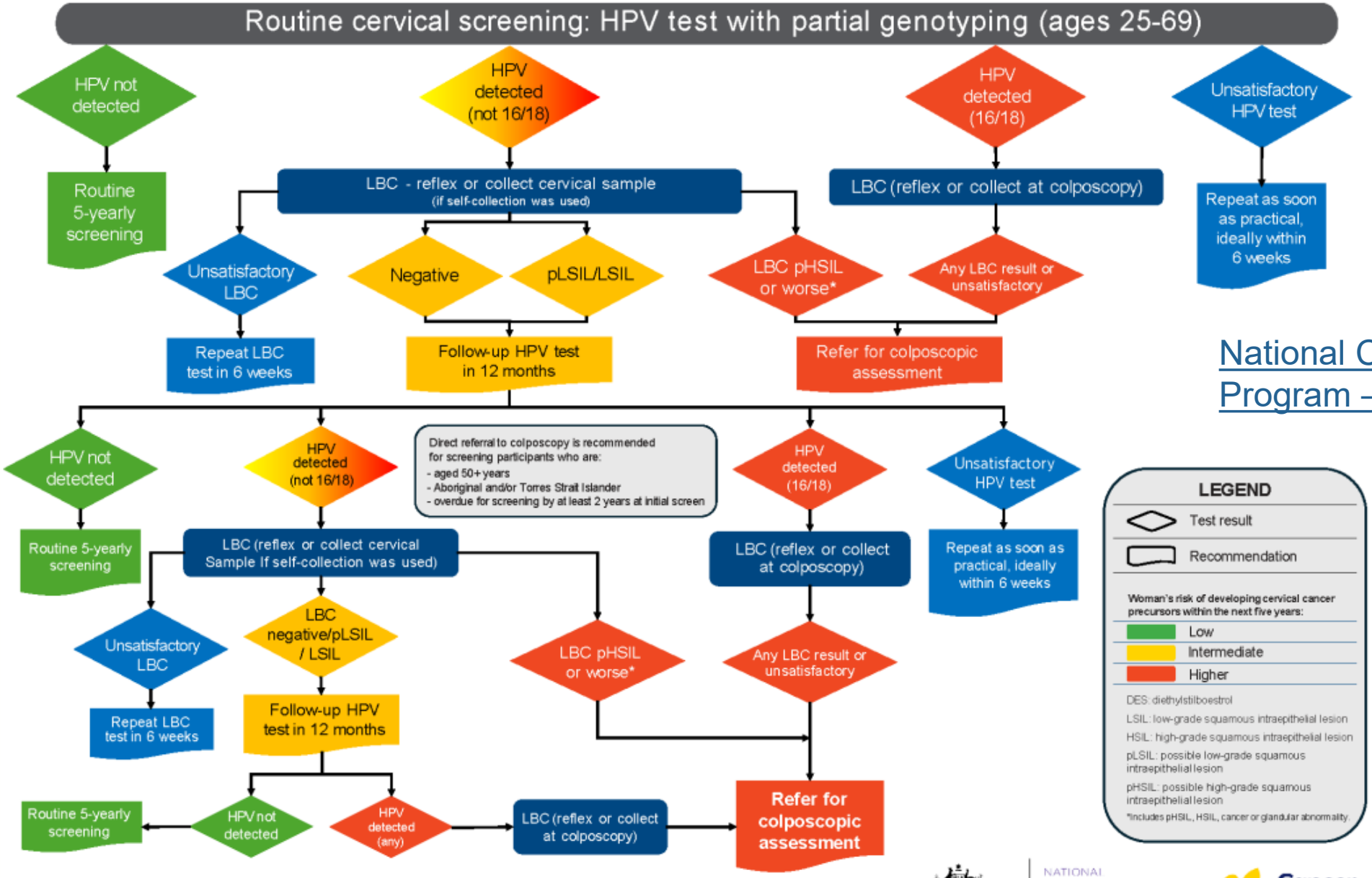
- Invasive cervical cancer rates are low in women ≤ 25 years, even in completely unvaccinated populations. Substantial evidence has found that cervical screening in this age group has little or no impact on the risk of developing invasive cancer before age 30 years.
- Testing for the presence of HPV gives **long lead time** to detect before cell changes start to occur.
- Consider single CST between 20 - 24 years who experienced their first sexual activity at a young age (e.g., <14 years) or if not received HPV vaccine before sexual activity commenced.
- Adolescent patients with abnormal HPV should follow the same pathway as adult patients.
- Patients < 30 years old should also have screening for STI as they are a high-risk group.
- Consider using oestrogen cream +/- liquid cytology in post-menopausal patients (continue until age 70-74 years with “exit” test)
- Recall women in 6-12 weeks if they have an unsatisfactory screening result
- Specific efforts should be made to provide screening for Aboriginal and Torres Strait Islander women (double the cervical cancer incidence)
- Provide support for under- and never-screened participants, as they may need additional and individualised support to accept screening and progress along the screening pathway.

From RYP - https://metrosouth.health.qld.gov.au/referrals/gynaecology/abnormal-pap-smear

Clinical Resources: National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding.

https://cancercouncilaustralia.mediavalet.com/galleries/5cf3c229-b772-48fe-be1c-b3812fa0125a_ba03fe13-1304-42ff-aaa1-b2cfa89f2416-ExternalUser





[National Cervical Screening Program – Quick Reference Guide]

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Cervical screening pathway. *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding*. CCA 2016. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening. Updated January 2025.

Australian Government | NATIONAL CERVICAL SCREENING PROGRAM | Cancer Council

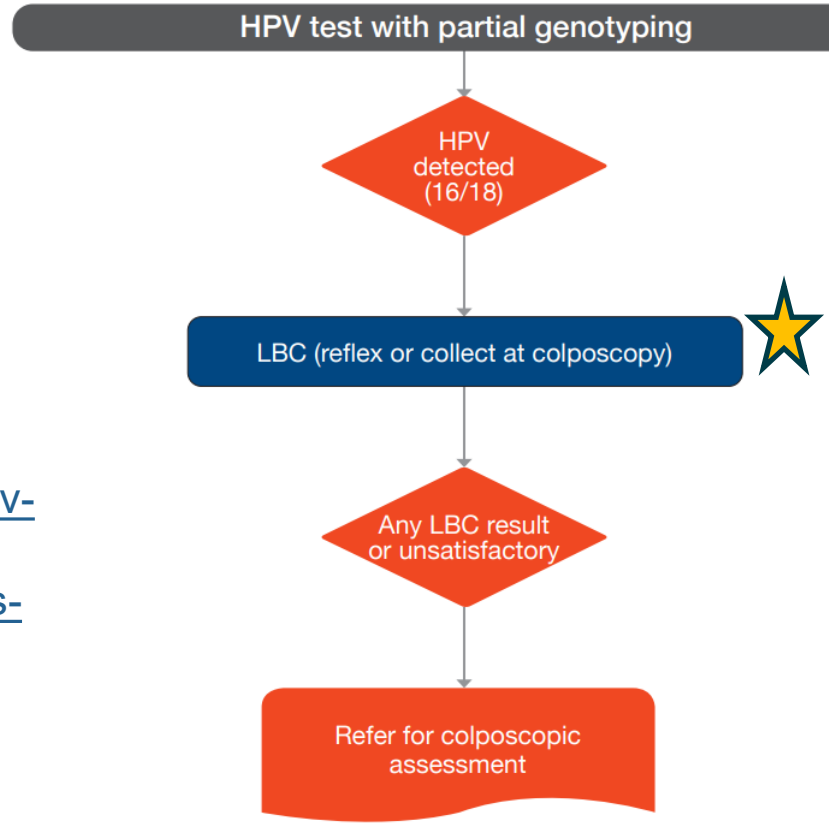
CERVICAL SCREENING PATHWAY (CLINICIAN COLLECTED OR SELF-COLLECTED)

CLINICAL GUIDELINES SITEMAP

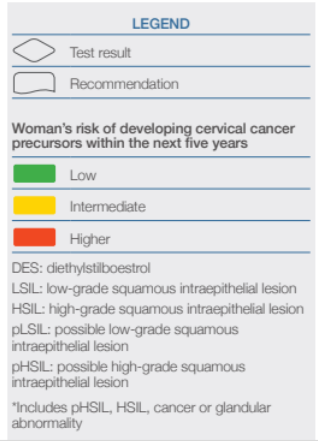
Cancer Council Australia

HPV 16/18 positive – approximately 2%

[flowchart-6-3-cervical-screening-pathway-for-primary-oncogenic-hpv-screening-hpv-tests-on-clinician-collected-or-self-collected-samples-hpv16-18-detected]

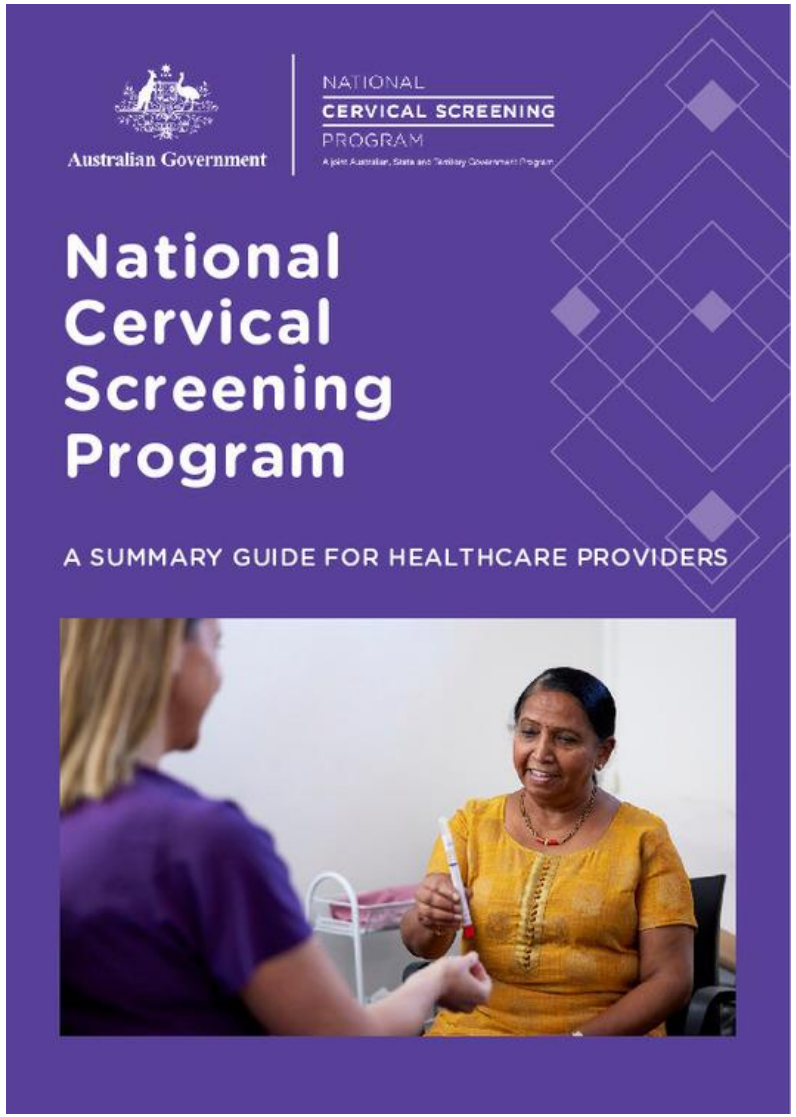


[Management of oncogenic HPV test results | Cancer Council]



If HPV of any type detected on self-collect CST – please consider clinician collected CST, as this may influence the patient triage position for colposcopy (ensuring those with HSIL on LBC seen first. Not required in referral but highly appreciated by O & G Team to assist in triage.

ncsp-summary-guide-for-health-care-providers



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HPV non 16/18 positive – approximately 6%

- Return for clinician-collected cervical sample for LBC as soon as practical, ideally within 6/52
- The incidence of HPV (not 16/18) is **highly age dependent**:

NCSR data - incidence of HPV (not 16/18)			
25-29 years	17%	50-54 years	4%
30-34 years	10%	55-59 years	3%
35-39 years	6%	60-64 years	3%
40-44 years	5%	65-69 years	3%
45-49 years	4%	70-74 years with HPV (not 16/18) – refer for colposcopy	

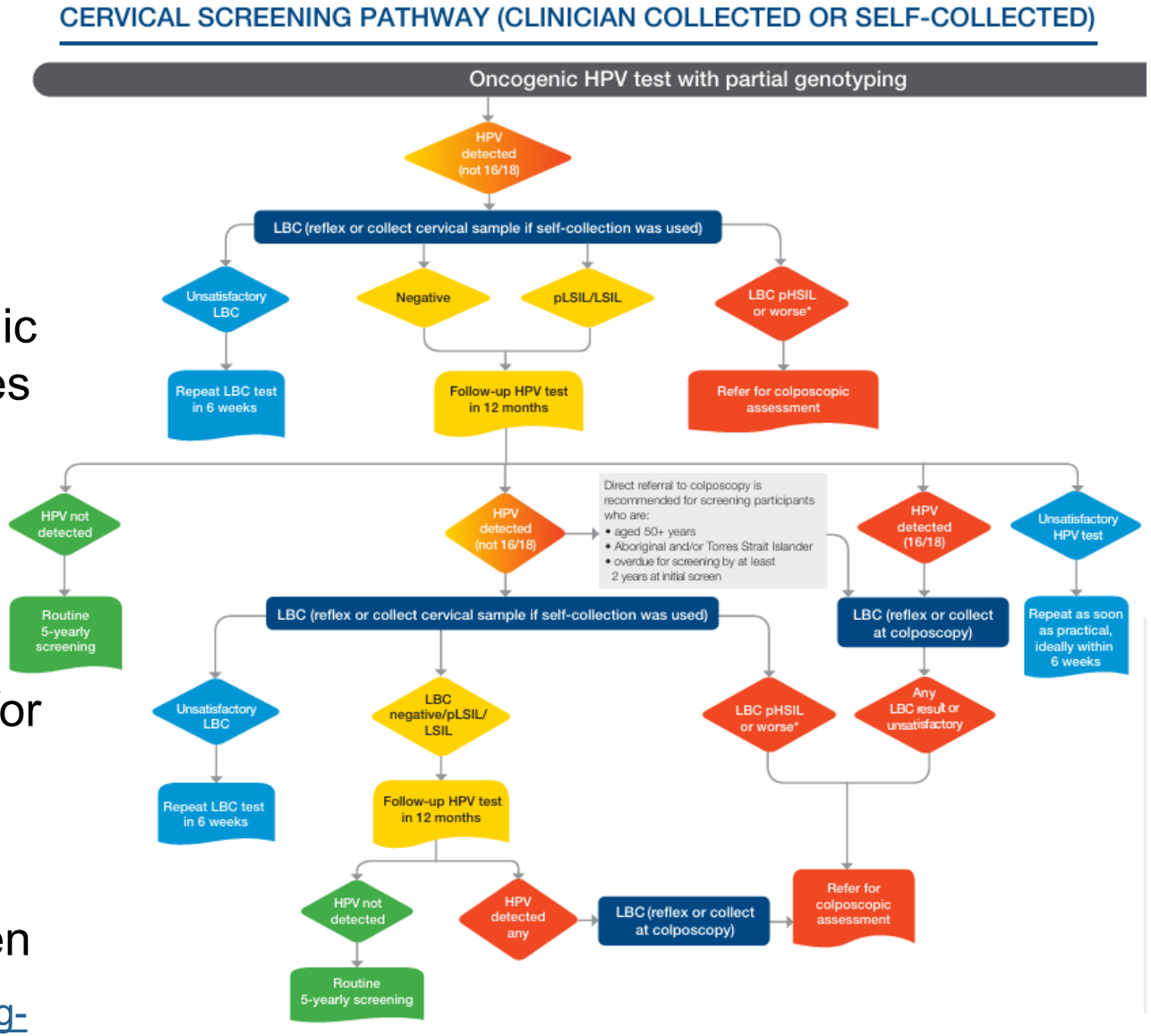
HPV non 16/18 positive

If positive non-16/18 but normal or LSIL on LBC DO NOT need referral unless persistent on TWO further repeat CSTs (at 12 & 24 months) *

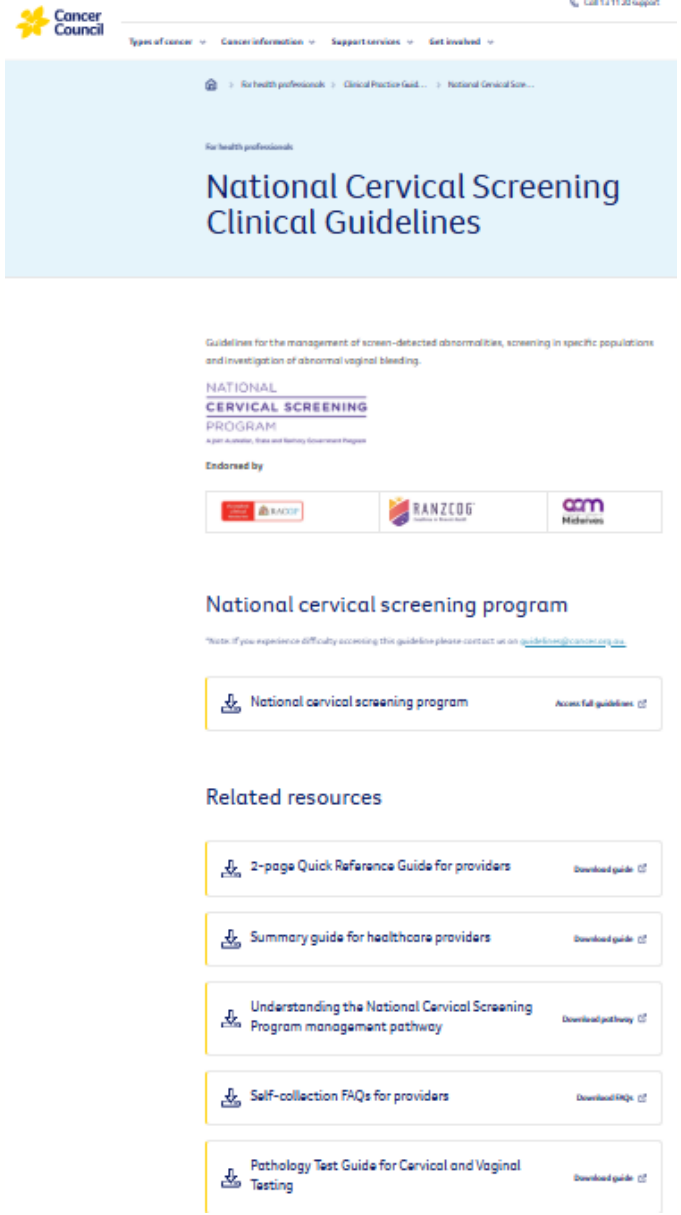
If both HPV type 16 and/or 18 and other oncogenic HPV types (not 16 /18) - manage as for HPV types 16/18

* EXCEPTIONS:

- non 16/18 in patient 70-74yrs – for immediate colposcopy
- after TWO non 16/18 HPV positive tests refer for colposcopy if –
  - Aged 50yrs+
  - Aboriginal and/or Torres Strait Islander
  - Overdue by at least 2 years on initial screen



https://cancer.org.au/assets/pdf/flowchart-6-4-cervical-screening-pathway-for-primary-oncogenic-hpv-screening-hpv-tests-on-clinician-collected-or-self-collected-samples-hpv-not-16-18-detected



Cervical Cancer Screening Guidelines | Cancer Council Australia

Primary care-relevant changes:

- New chapter, *Cervical screening in clinical practice*, co-locates new & existing content relevant to cervical screening in primary care into one location.

- **Post-treatment management ('Test of cure') ToC recommendations** for people successfully treated for high-grade squamous intraepithelial lesion (HSIL) or adenocarcinoma in situ (AIS) have changed.
  - People treated for HSIL, recommend annual HPV tests (rather than co-tests) until two CONSECUTIVE NEGATIVE tests 12 months apart (neg for HPV 16/18), at which point can return to routine 5- yearly screening.
  - People with HPV non-16/18 detected on three consecutive post treatment annual tests, should be referred for further colposcopy.
  - HPV test includes self-collect as well as clinician collected sample.
  - Cytology test no longer required for ToC.
  - Follow-up testing after completely excised AIS (annual co-tests) has been extended to 3-yearly testing if all tests have negative for 5 years and can cease 25 years after completely excised AIS if all tests have been negative.

- Where testing is indicated **after a total hysterectomy**, simplified to annual testing (co-testing or HPV testing, depending on cervical pathology, reason for hysterectomy and screening history) until oncogenic HPV is not detected on two consecutive occasions

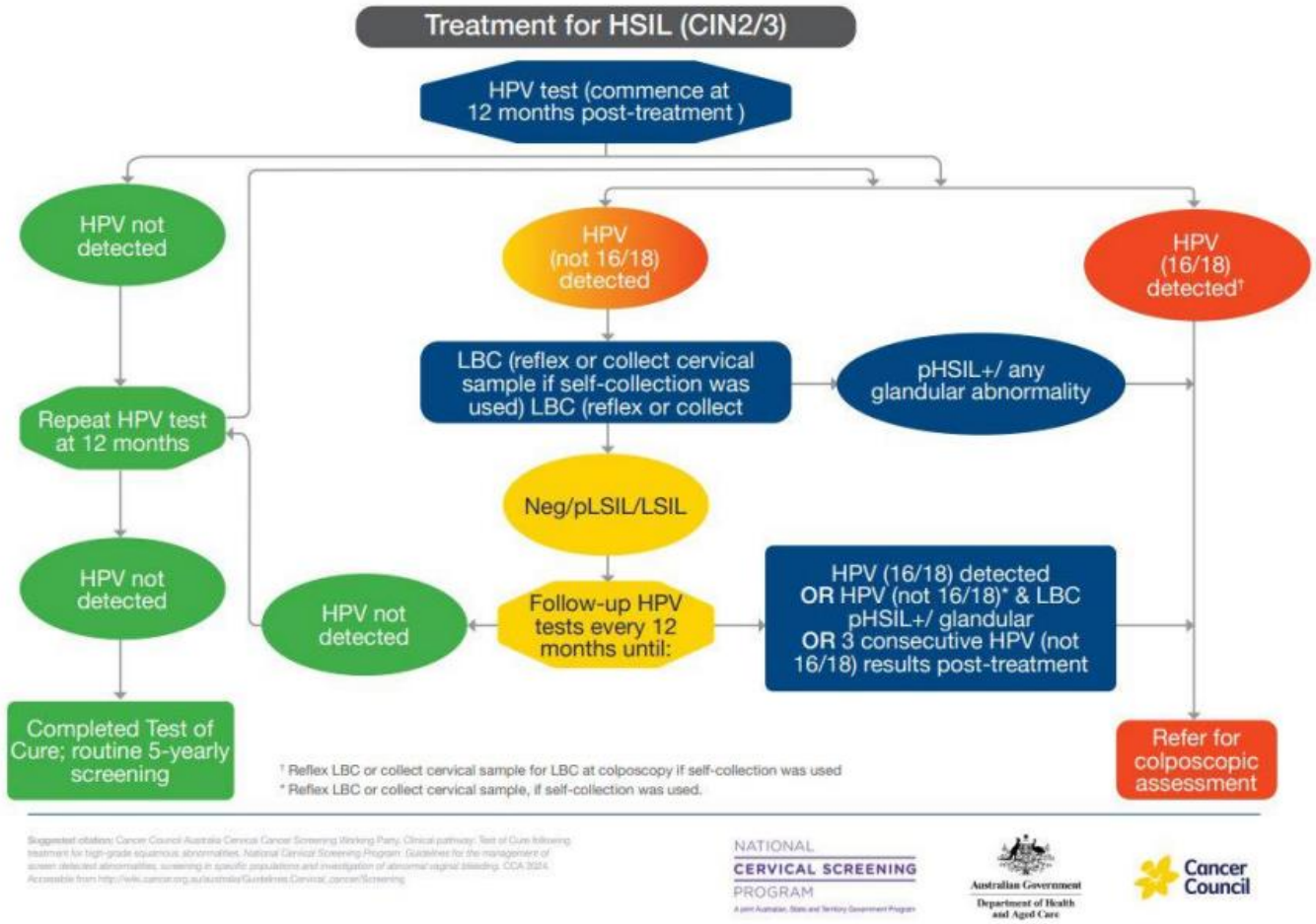
- Participants with oncogenic HPV (not 16/18) detected on self-collected sample **who do not return until > 9 months** after HPV test should be offered follow-up self-collected HPV test, rather than LBC, to determine if HPV infection now been cleared & person can return to routine screening.

- Categories of people for whom specific screening is needed due to **immune-deficient status** have been clarified and expanded.

Changes to Test of Cure after treatment for HSIL (CIN2/3) were made to the NCSP Guidelines in 2025 – FLOWCHART

- Patients who receive treatment for a high-grade abnormality should complete Test of Cure (ToC) surveillance to confirm their treatment has been successful.
- A review of new evidence recommended participants 12-months post-treatment for HSIL (CIN2/3), may have **annual HPV tests instead of co-tests**, commencing 12 months after treatment. HPV testing can be performed by the participant's usual healthcare provider. This can be done by a self-collected or clinician-collected sample, depending on the participant's preference.
- After 2 consecutive annual '**HPV not detected**' tests, the participant can return to routine screening.
- In the case of positive margins, the treating healthcare provider may elect to perform annual co-testing, rather than HPV alone. This should be decided on a case-by-case basis.

Figure 3: Test of Cure following treatment for high grade squamous abnormalities



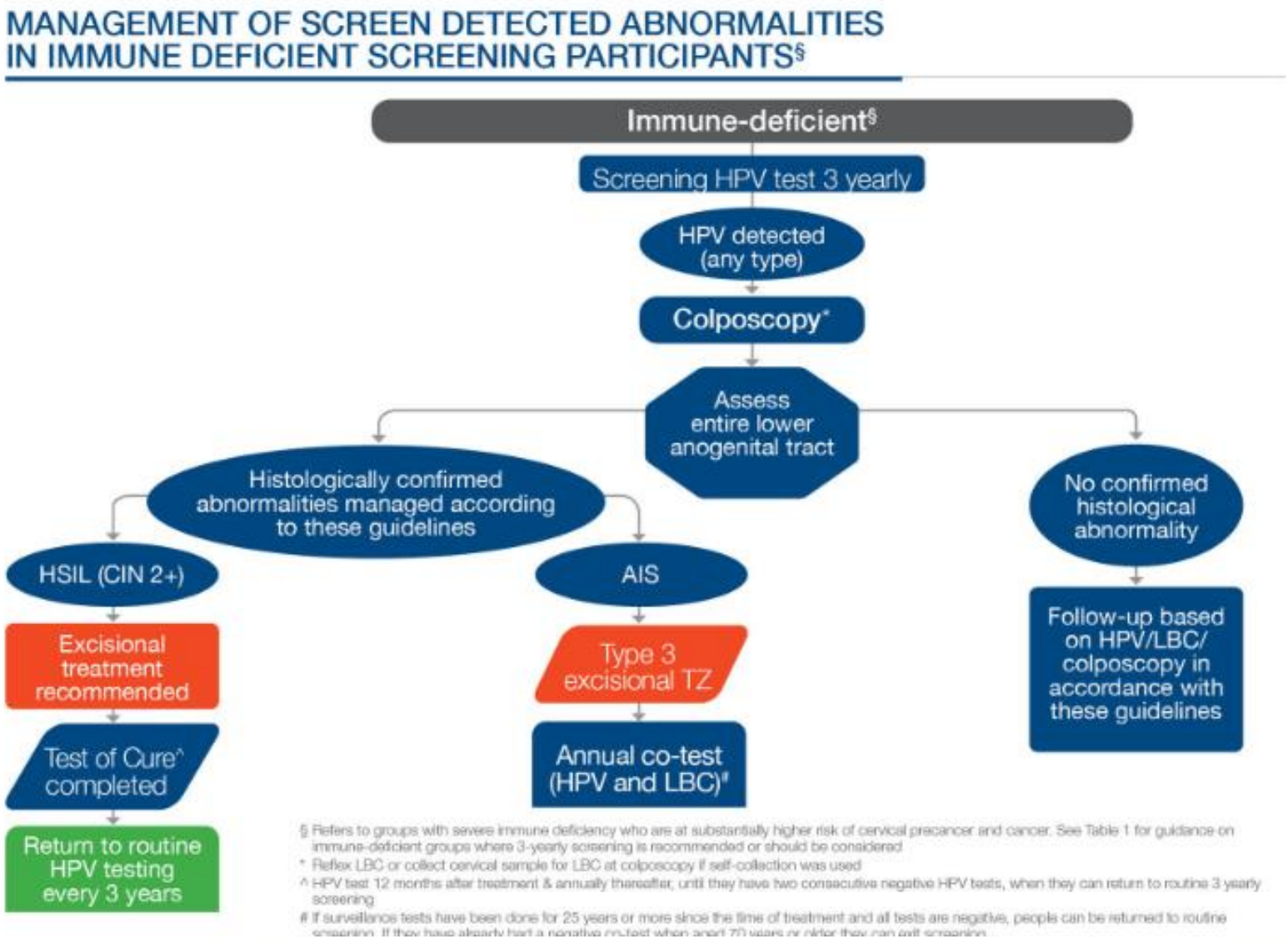
National Cervical Screening Program: a summary guide for healthcare providers

CST Screening in Immune Deficient People

- Immune-deficient participants assessed as being at substantially increased risk of cervical cancer and in whom oncogenic HPV is not detected should be screened every 3 years with HPV test. (CONSENSUS STATEMENT)
- Patients should be educated regarding their increased risk and encouraged to attend for regular screening every 3 years.
- Immune-deficient refers to people with **severe acquired or congenital immune deficiency**, who are deemed to have, or be at substantially higher risk of cervical precancer and cancer (see Table 7.1 in (See Table 7.1 and section 7.2 National Cervical Screening Program Guidelines)
    - Includes haemodialysis/peritoneal dialysis patients, high dose corticosteroids (> 20mg daily for 6/12), sDMARDS for > 6/12 including Methotrexate ≥10 mg/week), azathioprine (≥1 mg/kg day), 6-mercaptopurine (≥0.5 mg/kg/day)
    - If highly immunosuppressive condition resolves +/- use of specific medications ceases, increased cervical cancer risk progressively decreases to that of general population, and 5-yearly screening could resume.
    - Additionally, while some conditions or medications may not individually reach the threshold for 3-yearly screening, significant increase in immunosuppression may occur with combination of multiple conditions and/or prolonged use of specific medications and may justify 3-yearly rather than 5-yearly screening. Specialist responsible for managing the immunosuppressant medications or condition may be of assistance in supporting decision-making.
- People with a range of risks up to a moderate increase in risk (e.g. smoking or medical conditions, such as inflammatory bowel disease, solid neoplasms, etc) are well protected if they follow the NCSP recommendations for the general population (5-yearly screening).
- Most biological drugs do not significantly deplete T cells, and generally people using these medications are well protected if they follow the NCSP recommendations for the general population (5-yearly screening) , since these already include people up to a moderate increase in risk.
- Most evidence related to high-risk groups references transplant patients and people living with HIV. Most of the advice on other conditions is extrapolated from these studies.

Flowchart 7.2 - Management of screen detected abnormalities in immune-deficient screening participants

https://www.cancer.org.au/assets/pdf/clinical-guidelines/management-of-screen-detected-abnormalities-in-immune-deficient-screening-participants



* Surveillance after treatment for Adenocarcinoma in situ (AIS)

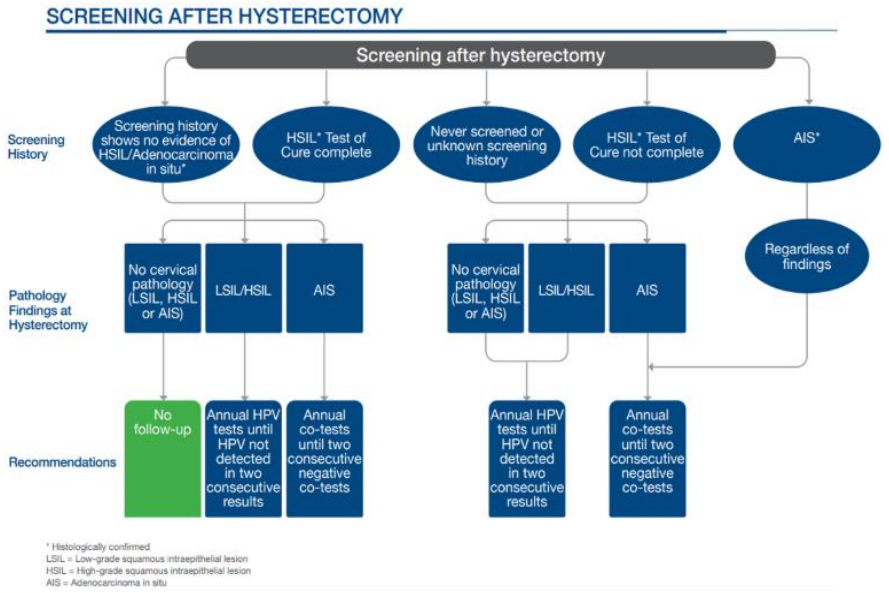
Note: Important changes were made to NCSP Guidelines in 2025 regarding surveillance after treatment for AIS for those with complete excision and clear margins.

- Histological confirmation of AIS lesions often occurs as the result of a diagnostic excisional biopsy, usually a cold knife cone biopsy, which may or may not have completely excised the lesion.
- If AIS is incompletely excised or if the margins cannot be assessed, further excision to obtain clear margins should be performed.
- Instead of indefinite annual co-testing, these participants should undergo annual co-testing for 5 years. After 5-years, if all co-tests have been negative (oncogenic HPV not detected and LBC negative), surveillance testing can be extended from annually to every 3 years.
- If surveillance tests have been performed for 25 years or more since the time of treatment, and all tests are negative, the recommended pathway depends on the screening participant's age.
  - Patients aged less than 70 years can return to routine screening.
  - Patients aged 70 years or older can safely exit routine screening if they have had at least 1 co-test with no oncogenic HPV detected and negative LBC test since turning 70

- If a participant chooses to ‘opt out’ of NCSR, healthcare providers can arrange this through the Healthcare Provider Portal. Participants or their personal representatives can ‘opt-out’ by accessing the NCSR Participant Portal via MyGov or by calling the NCSR on 1800 627 701. Opting out of the NCSR for cervical screening will not opt this person out of other screening programs (i.e. bowel screening). The person can re-join the NCSP at any time.

After Total Hysterectomy:

- Vaginal vault cytology can enable screening for pre-invasive disease of the vagina such as vaginal intraepithelial neoplasia (VAIN) or recurrence of previously treated cervical or vaginal cancer.
- High-grade cervical intraepithelial neoplasia (CIN), prior to or at the time of total hysterectomy = known risk factor for development of secondary VAIN, with reported recurrence rates of 0.9–7.4%
- However, VAIN is far less common than CIN and incidence of vaginal cancer is less than a third of the incidence of cervical cancer, accounting for less than 0.5% of all cancers in Australian women
- Post total hysterectomy - do not need further surveillance if both the following conditions apply:
  - Has been treated for histologically confirmed HSIL and has completed Test of Cure in accordance with National Cervical Screening Program (NCSP) guidelines.
  - No evidence of cervical pathology was detected on the hysterectomy specimen
- People who have had a total hysterectomy should be advised to complete Test of Cure if they have been treated for histologically confirmed HSIL but have not completed Test of Cure.



CST Screening after total hysterectomy –

https://www.cancer.org.au/assets/pdf/7-3-screening-after-hysterectomy

Resources are available on the National Cervical Screening Program website

The following resources are available on the National Cervical Screening Program website to support conversations with patients about the Cervical Screening Test.

Resources for general audiences

Available on the NCSP website (www.health.gov.au/ncsp)

- Promotional poster
- Cervical Screening Test – your choices explained visual guide
- Cervical screening explainer video
- Self-collection instructional video
- Self-collection instructional visual guide
- What happens when my healthcare provider collects my sample visual guide
- Understanding results booklet

Easy read and translated resources

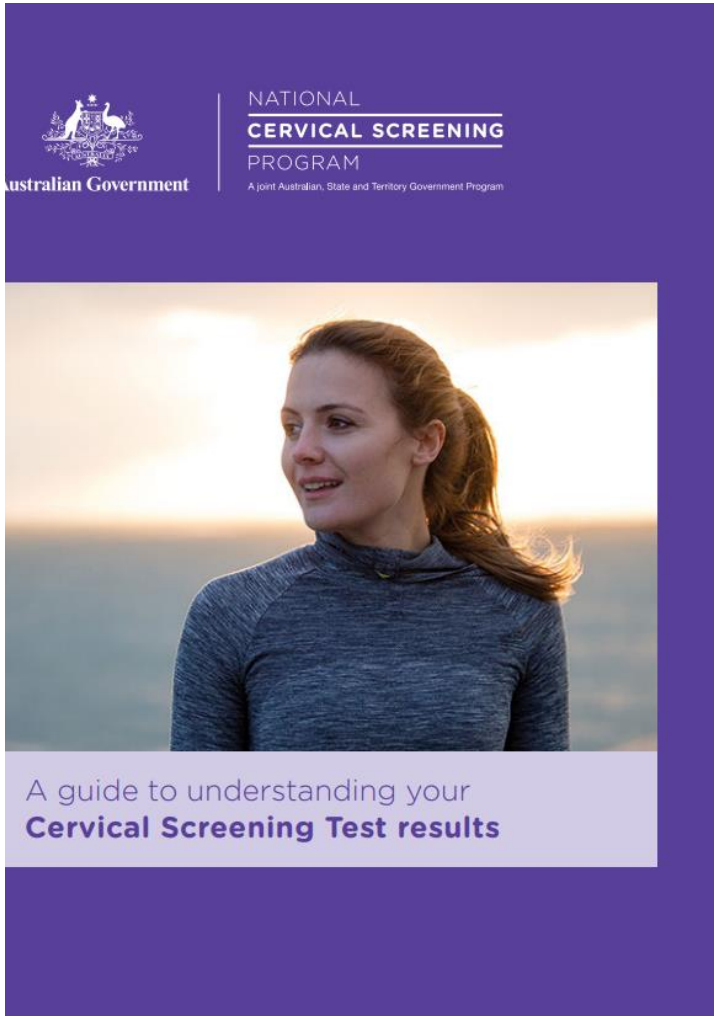
Available on the NCSP website:

- About the Cervical Screening Test (Easy Read)
- Understanding choice visual guide
- Self-collection visual guide
- Understanding choice explainer video
- Self-collection instructional video
- Understanding results visual guide

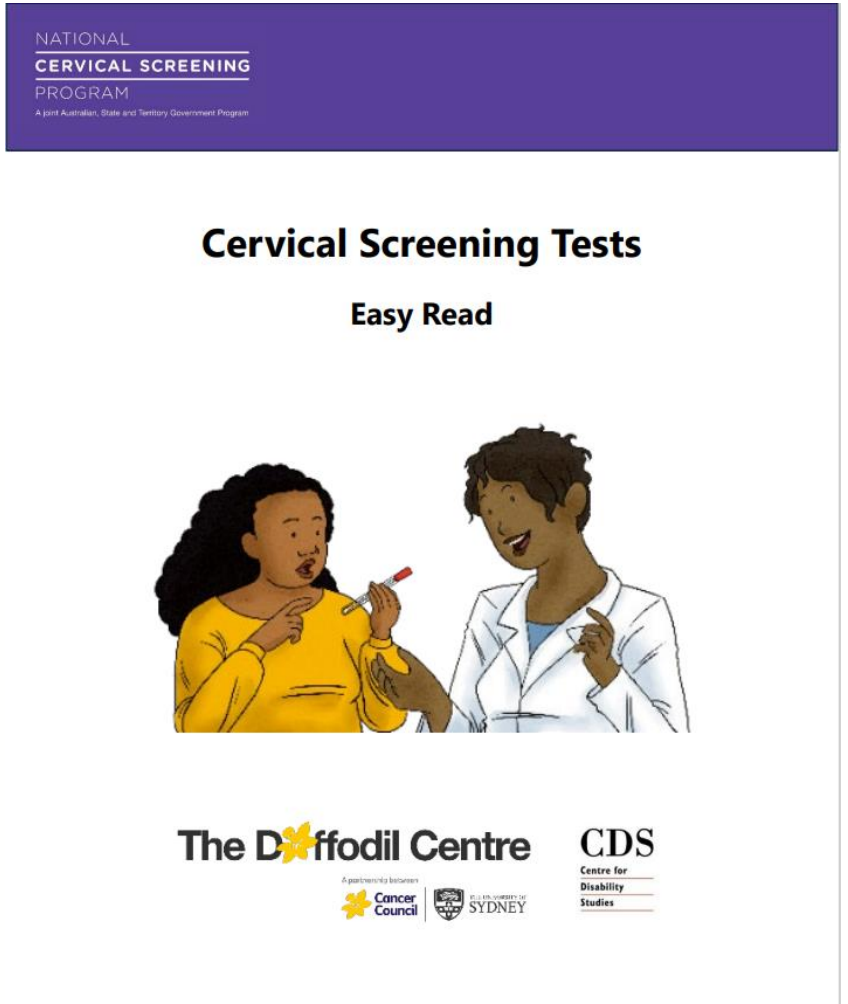
Resources for Aboriginal and/or Torres Strait Islander peoples

Available on the NCSP website:

- Promotional poster
- Cervical screening information sheet
- Self-collection instructional video
- Self-collection instructional visual guide
- Case study
- Understanding results visual guide



A guide to understanding your Cervical Screening Test results



National Cervical Screening Program – The Cervical Screening Test – Easy Read

Effects of Persistent HPV infection

- Mostly LSIL lesions = acute HPV infection with any type (oncogenic types or other types such as 6, 11), rather than cancer precursors and most will resolve spontaneously within 12 months.

- Some HSIL [CIN2] will regress over time, but these lesions are associated with a higher risk of progression compared with LSIL.

- Pre-cancerous lesions occur when oncogenic HPV is not cleared, infects immature cells and prevents maturation and differentiation, resulting in the replication of immature cells and the accrual of genetic changes that can lead to cervical cancer. The time from HPV infection to cervical cancer is usually 10–15 years or more.

- After the introduction of HPV vaccination in 2007 (males from 2013), Australia experienced rapid falls in vaccine included oncogenic HPV types infection rates; in anogenital warts and in histologically confirmed HSIL (now documented extensively in young females & also in heterosexual males due to herd immunity effects)

Symptomatic patients

Participants who have signs or symptoms suggestive of cervical cancer are tested and **managed on a different clinical pathway** from those who are asymptomatic. Not eligible for screening, but rather for investigation and diagnosis.

Abnormal vaginal bleeding can occur at any age - most commonly associated with other conditions, such as:

- polyps
- adenomyosis
- leiomyomas (fibroids)
- coagulopathies
- ovulatory disorders
- endometrial disorders
- hormonal contraception
- iatrogenic causes
- sexually transmitted infections

Following types of abnormal vaginal bleeding can be suggestive of cervical cancer:

- unexplained intermenstrual vaginal bleeding
- persistent post-coital bleeding
- any post-menopausal bleeding

When to test: **Patients at any age with these types of vaginal bleeding should have a co-test.** They should also be referred for specialist investigation to exclude genital tract malignancy, regardless of the result of the co-test.

A **self-collected test is not appropriate in this situation** as it is HPV test only and cannot detect further advanced cancerous cells.

Note: False negative test results are more common for both the HPV test and LBC in the setting of vaginal bleeding. If the participant returns a negative co-test but still presents recurrent or persistent postcoital bleeding, they should be referred for investigations to exclude genital tract malignancy. This includes if they have persistent unexplained inter-menstrual bleeding or post-menopausal bleeding.

CST/HPV self-collections

- All people with a cervix aged 25-74 years, who have ever been sexually active, including those who are pregnant
- Asymptomatic patients who are starting or attending their 5 yearly screening (or 3 yearly if immunocompromised)
- Self-collection can also be offered at other points where only an HPV test is required including:
  - At the 12-month follow-up after an intermediate risk result
  - At the 12-month follow-up after normal or CIN1 colposcopy
  - At the 12-month and 2 year in those who are undergoing “test of cure” after treatment for high-grade squamous intraepithelial lesion (HSIL) or post hysterectomy with a history of HSIL.

Ineligible patients

- Patients who have recorded negative HPV test results within the past five years.
- Patients who require a co-test for one of the following reasons, including patients:
  - with symptoms suggestive of cervical cancer e.g., unexplained bleeding, unexplained persistent discharge
  - who have been treated for a glandular abnormality, including adenocarcinoma in situ (AIS)
  - who have been exposed to diethylstilboestrol (DES) in utero
  - Consider in those who have had a total hysterectomy with a history of HSIL (co-test or HPV test depending on cervical pathology at hysterectomy and screening history)

Importance of self-collection as option for participants providing level of control and choice by removing significant barrier to screening participation, particularly in groups that are less likely to screen:

- Aboriginal and/or Torres Strait Islander women;
- culturally and linguistically diverse communities;
- people who identify as LGBTIQ+;
- people with disabilities;
- people who have experienced sexual violence;
- post-menopausal women;
- and people who have had previous negative cervical screening experiences.

CST/HPV self-collections vs Clinician collected

Accuracy of a self-collected sample for detection of HPV

- Sensitivity and specificity of HPV testing to detect CIN2+ in self-collected samples **equivalent** to those for clinician-collected samples (using validated PCR-based HPV assays)
- When deciding whether to choose self-collection or clinician-collection, patients must be given clear information by their healthcare provider about likelihood that HPV may be detected and, if so, what follow-up will be required.
- Among women undergoing routine screening, approximately 2% have HPV 16/18 detected and approximately 6% have HPV (not 16/18) detected, although the latter varies by age. Over 90% test negative - can safely return to screen in five years' time.
- Approximately **10% of self-collected samples HPV positive** - these women will need to return for clinician collected specimen for LBC cytology triage.
  - If positive for HPV 16/18 referral can be made for Colposcopy with LBC at that appointment (but added information given by subsequent clinician collected LBC may assist in hospital triage process)
  - If HPV (not 16/18) detected, and normal or LSIL on LBC, repeat by clinician for co-test in 12 months

Information for Health Care Professionals about Cervical Self-Screening - Cancer Council

More resources and education: https://acpcc.org.au/practitioners/resource-hub/

Why should I offer self-collection?

- Self-collection = **overcoming barriers** to screening and **highly acceptable**, particularly among under-screened and never screened.
- Under-screening is **main risk factor** for developing cervical cancer, with >70% Australians diagnosed from under-screened or never screened cohort.
- Women diagnosed through cervical screening had an 87% lower risk of dying from cervical cancer than women who had never had a cervical screening test
- Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse communities, people with disability, LGBTQIA+ people, and people from rural and remote areas are amongst those less likely to participate in screening, placing them at higher risk
- 1-2% samples reported invalid result, due to inadequate cellular material or the presence of interfering substances.

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- **Healthcare providers play key role in elimination of cervical cancer in Australia. Do your part by offering the option of self-collection & support your patients to make an informed choice about how they screen!**

- Pilot studies show that most will return for follow up after an HPV-positive self-collected sample
- Self-collect sample does not need to be taken from the cervix.
- No evidence to support routine pelvic examination for asymptomatic patients.
- Decision to perform PVE/visual inspection of genital tract should be patient centred, clearly clinically indicated & made collaboratively
- Use any time saved to check for symptoms and remind patients what to look out for.

https://acpcc.org.au/wp-content/uploads/2024/05/24079_KI_ACPCC_10FAQs_V2.pdf

Indications for Colposcopy after abnormal CST

- Patients with positive non-16/18 but normal or LSIL on LBC **DO NOT** need referral but a repeat CST at 12/12

If remains positive non-16/18 but normal or LSIL on LBC, REPEAT again in 12 months

(only refer if HPV non-16/18 positive on THREE consecutive tests (or clinical concerns)

- Women who have been treated for HSIL (CIN2/3) do not need a post-treatment colposcopy. Recommended these women have HPV test performed at 12/12 after treatment, and annually thereafter, until they have a negative co-test on two consecutive occasions, when they can return to routine 5 yearly screening. This is called '**Test of Cure**'.
- If, at any time post treatment, there is a positive oncogenic HPV (16/18) result, refer for colposcopic assessment (regardless of the reflex LBC result, but triage will be assisted if an LBC result is included with the referral .
- If, at any time during Test of Cure, the woman has an LBC prediction of pHSIL/HSIL or any glandular abnormality, irrespective of HPV status, she should be referred for colposcopic assessment.

From RYP - https://metrosouth.health.qld.gov.au/referrals/gynaecology/abnormal-pap-smear

Clinical Resources: National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding.

https://www.cancer.org.au/clinical-guidelines/cervical-cancer/cervical-cancer-screening/management-of-oncogenic-hpv-test-results/oncogenic-hpv-types-16-and-or-18

Does your patient meet the minimum referral criteria?

Category 1
(appointment within 30 calendar days)
 	
If you feel your patient meets Category 1 criteria, please mark "urgent" on your referral
	• Invasive cancer (Squamous, glandular, other). For optimum care, patient should be seen by gynaecological oncology (National guidelines suggests being seen at the earliest opportunity for urgent evaluation).
	• LBC of PHSIL/HSIL
	• **Positive HPV 16/18** ***(LBC not required prior to referral; review ideally within 8 weeks)***
	  ○ Unknown cytology
	  ○ Unsatisfactory LBC
	  ○ Previous treatment for PHSIL/HSIL(National guidelines suggests being seen at the earliest opportunity, ideally within 8 weeks).
	  ○ Past history of positive HPV 16/18(National guidelines suggests being seen at the earliest opportunity, ideally within 8 weeks).
	
	Glandular lesions
	
	• AIS or possible high grade glandular lesion
	• any atypical glandular cells/endocervical cells of undetermined significance

Cervical Cancer Screening - Community HealthPathways Brisbane South (SpotOnHealth)

If positive HPV 16 or 18, GP undertaken LBC will assist triage process for the Colposcopy Clinic, and reduce the overall wait time for Cat 1 appointments.

REFER YOUR PATIENT – METRO SOUTH HHS

Abnormal cervical screening / cervical dysplasia / abnormal cervix

If your patient does not meet the minimum referral criteria

- Assessment and management information can be found on a range of conditions at Brisbane South HealthPathways
- If the patient does not meet the criteria for referral but the referring practitioner believes the patient requires specialist review, a clinical override may be requested.
- Please explain why (e.g., warning signs or symptoms, clinical modifiers, uncertain about diagnosis, etc.)
- Please note that your referral may not be accepted or may be redirected to another service.

REFER YOUR PATIENT – METRO SOUTH HHS

Abnormal cervical screening / cervical dysplasia / abnormal cervix

Category 2 (appointment within 90 calendar days)	• Positive HPV 16/18 **and** normal LBC • PLSIL/LSIL • Positive HPV non 16/18 **and Persistent** positive non 16/18 HPV or HPV other - on 3 consecutive yearly tests - on 2 consecutive test and ○ two or more years overdue for screening at time of the initial screen ○ identifies as Aboriginal or Torres Strait islander ○ aged 50-69 years - on a single test in ○ women aged 70+ ○ immune deficient women ○ women currently undergoing Test of Cure following treatment of histological HSIL • History of diethylstilboestrol (DES) exposure in utero regardless of HPV status or LBC test • Abnormal appearing cervix with normal cervical screening • Recurrent post-coital bleeding in pre-menopausal woman after STI excluded/treated – gynaecological assessment recommended • Any episode of unexplained vaginal bleeding (including post-coital) in a post-menopausal woman • Unexplained persistent unusual vaginal discharge, especially if offensive and blood stained and after STI excluded/treated • Any abnormal result and past history of excisional treatment of AIS
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

Essential referral information for Abnormal cervical screening / cervical dysplasia / abnormal cervix referrals (Referral will be returned without this)

- **History of**
  - Any abnormal bleeding (i.e., post-coital and intermenstrual)
  - Unexplained persistent deep dyspareunia or unexplained persistent unusual vaginal discharge
  - Previous abnormal cervical screening results and any treatment (results to be included in referral)
  - Immunosuppressive therapy
- Medical management to date
- Most recent and current cervical screening results (LBC should be performed on any sample with positive oncogenic HPV)

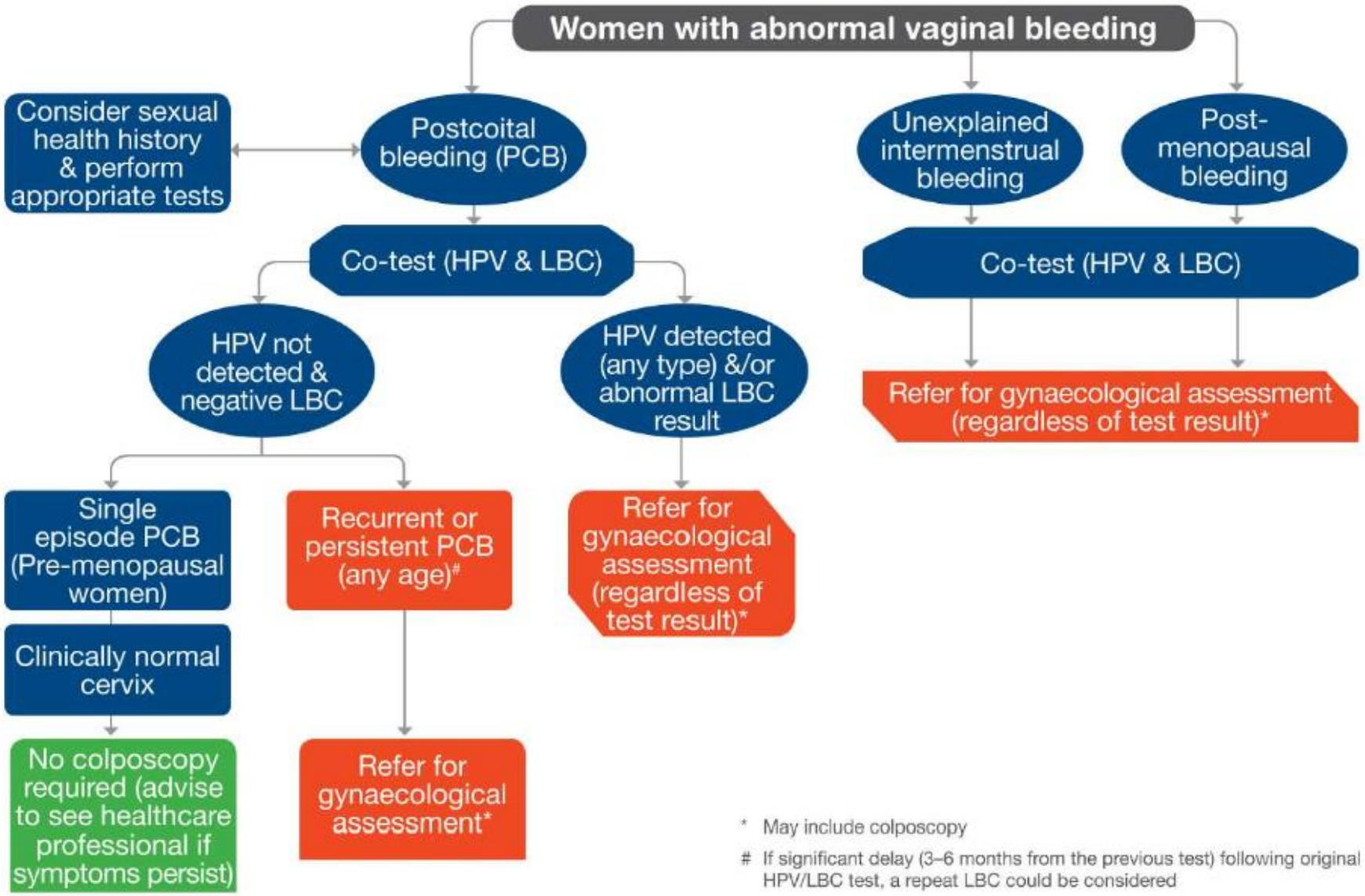
If a specific test result is unable to be obtained due to access, financial, religious, cultural or consent reasons a Clinical Override may be requested. This reason must be clearly articulated in the body of the referral.

Additional referral information for Abnormal cervical screening / cervical dysplasia / abnormal cervix referrals

- BMI
- HPV Vaccination history
- STI screen result, endocervical swab (preferred and can be self–collect swab) or first catch urine for chlamydia +/- gonorrhoea NAA
- History of smoking/vaping

Abnormal cervical screening / cervical dysplasia / abnormal cervix | Referrals to Gynaecology | Metro South Health

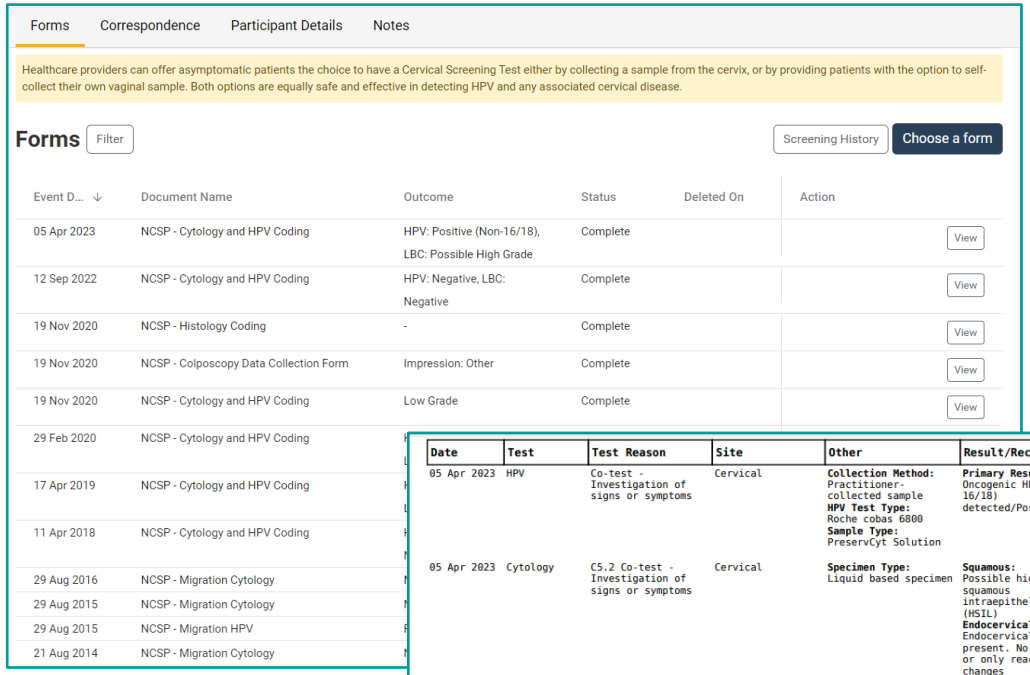
INVESTIGATION OF WOMEN WITH ABNORMAL VAGINAL BLEEDING



* May include colposcopy

\# If significant delay (3–6 months from the previous test) following original HPV/LBC test, a repeat LBC could be considered

Checking prior CST/PAP smear results on PRODA



Date	Test	Test Reason	Site	Other	Result/Recommendation
05 Apr 2023	HPV	Co-test - Investigation of signs or symptoms	Cervical	**Collection Method:** Practitioner-collected sample **HPV Test Type:** Roche cobas 6800 **Sample Type:** PreservCyt Solution	**Primary Result:** Oncogenic HPV (not 16/18) detected/Positive NOS
05 Apr 2023	Cytology	C5.2 Co-test - Investigation of signs or symptoms	Cervical	**Specimen Type:** Liquid based specimen	**Squamous:** Possible high-grade squamous intraepithelial lesion (HSIL) **Endocervical:** Endocervical component present. No abnormality or only reactive changes **Other/non-cervical:** No other abnormal cells **Recommendation:** Refer for colposcopic assessment
12 Sep 2022	HPV	Co-test - Test Of Cure	Cervical	**Collection Method:** Practitioner-collected sample **HPV Test Type:** Roche cobas 6800 **Sample Type:** PreservCyt Solution	**Primary Result:** Oncogenic HPV not detected
12 Sep 2022	Cytology	C5.1 Co-test - Test of cure	Cervical	**Specimen Type:** Liquid based specimen	**Squamous:** Cell numbers and preservation satisfactory. No abnormality or only reactive changes **Endocervical:** Endocervical component present. No abnormality

(a) AIHW codes are used for cytology & HPV results.
(b) SNOMED CT codes are used for histology results for the renewed cervical program.
(c) Colposcopy data dated before 1/12/2017 may not indicate glandular abnormality separately, and has been mapped to High Grade or Cancer.
(d) NCSR alerts are flags set in NCSR to indicate clinical circumstances that require special management and alternative pathways may apply. Refer to the *National Cervical Screening Program: Guidelines for the management of screen-detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding* for further information about pathways and the NCSR Healthcare Provider Portal User Guide or Clinical Information System Integration guides for further information about alerts.
(e) Dual stain results are included in screening histories where this information is available for participants who were on the Compass Trial. Dual stain results were used by the Compass Trial but are not yet part of the NCSP, and are not used in NCSR cervical pathways.

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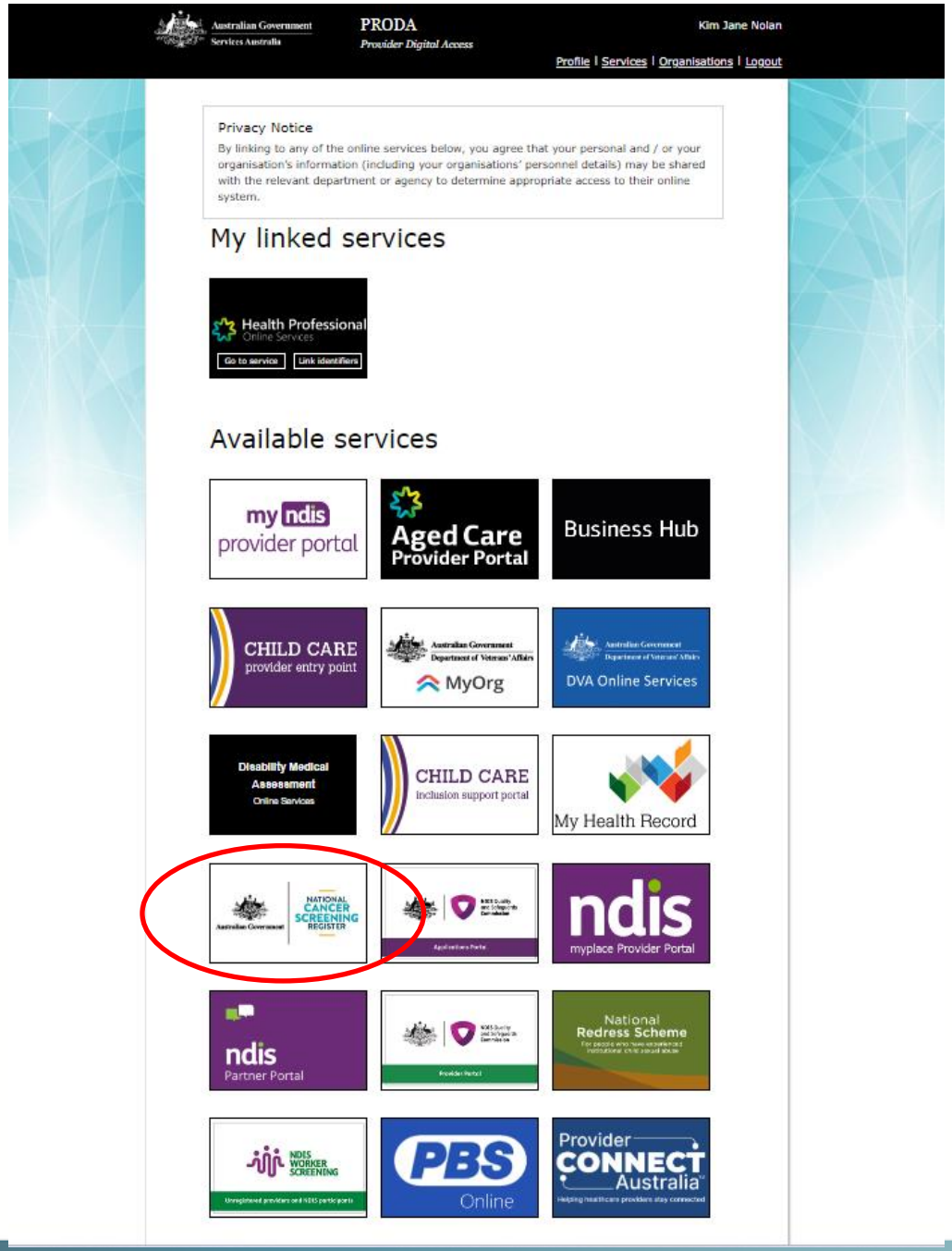
Sender: NCSR 1800 627 701



National Benchmark Rates (current as of 4th May 2026) are calculated using Registry data collected from 5 January 2026 to 3 May 2026.

Collection method	Age cohort	Positivity rate	Unsatisfactory rate
HCP collected primary screening tests	Overall	8.5%	0.2%
	Pre-1980	5.8%	0.2%
	Post-1980	10.3%	0.2%
Self-collected primary screening tests	Overall	10.2%	1.3%
	Pre-1980	8.2%	1.3%
	Post-1980	11.8%	1.3%

The percentage of clinician collected laboratory specimens that are reported as unsatisfactory for HPV NAT testing should not exceed 0.5%.

HPV positivity rates | National Cancer Screening Register

Self-Collect samples

MSAC evidence-based recommendation

REC6.4: Women with a positive HPV (16/18) test result

Women with a positive oncogenic HPV (16/18) test result should be referred directly for colposcopic assessment, which will be informed by the result of LBC. If the sample has been collected by a healthcare practitioner, then reflex LBC will be performed by the laboratory. If the sample was self-collected, then a sample for LBC should be collected at the time of colposcopy.

Oncogenic HPV types 16 and/or 18 | Cancer Council

https://www.cancer.org.au/clinical-guidelines/cervical-cancer/cervical-cancer-screening/management-of-oncogenic-hpv-test-results/oncogenic-hpv-types-16-and-or-18

NOTE: For MSHHS triage purposes, consider clinician collected CST with ALL HPV positive results Cell changes on LBC result will likely expedite patient access to colposcopy.

HPV vaccination – Gardasil 9

- Second-generation 9-valent vaccine - targets the quadrivalent oncogenic HPV types (6, 11, 16, and 18) & five additional oncogenic types (31, 33, 45, 52, and 58).
- Oncogenic HPV types included in the 9-valent vaccine are found in approximately 90% of cervical cancers globally
- Compared to the original quadrivalent vaccines, Gardasil 9 has been shown to be 97% effective for prevention of high-grade cervical, vulvar, and vaginal disease (caused by types 31, 33, 45, 52, and 58 in individuals naïve for these types), and to be associated with non-inferior seroconversion for the oncogenic HPV types 6, 11, 16, and 18.

https://www.cancer.org.au/clinical-guidelines/cervical-cancer/cervical-cancer-screening/the-rationale-for-primary-hpv-screening

Vaccine efficacy in people already infected with HPV

- Adults aged ≥26 years diagnosed with/having a history of HPV-related pre-cancerous/cancerous lesions may be considered for vaccination because of their inability to clear and control HPV infection, noting vaccination protects against future infections and does not have therapeutic benefits.

- The recommended schedule for adults aged ≥26 years is 3 doses, with an interval of 2 months between dose 1 and dose 2, and 4 months between dose 2 and dose 3 (PRIVATELY FUNDED $270-$300/dose)

- In women who are vaccinated who may have pre-existing HPV infection, **vaccine efficacy is lower** than in HPV-naive women (reduced vaccine effectiveness among females who are already sexually active)

The HPV vaccines are prophylactic vaccines — they prevent primary HPV infection.

- Vaccination does not:
  - treat an existing HPV infection
  - prevent disease that may be caused by an existing vaccine HPV-type infection

- HPV vaccine protection - predominantly antibody mediated, and because antibodies prevent viral entry, vaccination may still benefit sexually active women by protecting them against:
  - new infections with other vaccine-preventable HPV types
  - reinfection with vaccine-preventable types previously been exposed to — e.g., from an infected partner
  - auto-inoculation of existing persistent HPV infection to other sites

Human papillomavirus (HPV) | The Australian Immunisation Handbook (health.gov.au)

Pink Group – Task

- Marlene is 46 yo Aboriginal woman G4P4 - all SVD
- BMI 36kg/m2
- Heavy irregular periods
- Previous failed “in rooms” LNG-IUS insertion
- Pelvic/transvaginal USS day 7 - endometrium 6mm
- Fearful of hospitals
- No reliable transport or child-care

Outline your approach

Blue Group – Task

- Tahlia is an almost 15 yo young lady who presents with heavy irregular periods.
- Menarche aged 12 years but cycles infrequent in first 6-9 months.
- She attends the appointment with Mum
- She has been missing school frequently in the last few months, has stopped playing netball, and spent much of the recent family beach camping holiday in the tent, asleep or scrolling on her phone as she had her period.

Outline your approach

Metro South Health

Quality healthcare every day

Heavy Menstrual Bleeding

Dr Hasthika Ellepola
Acting Director Gynaecology
Obstetrics and Gynaecology Department
Logan Hospital

ICARE² values

INTEGRITY COMPASSION ACCOUNTABILITY RESPECT ENGAGEMENT EXCELLENCE

Queensland Government

Abnormal Vaginal Bleeding

See also Miscarriage and Ectopic Pregnancy.

Red flags

- Significant or uncontrolled vaginal bleeding
- Ectopic pregnancy
- Endometrial hyperplasia or suspicion of cancer

Background

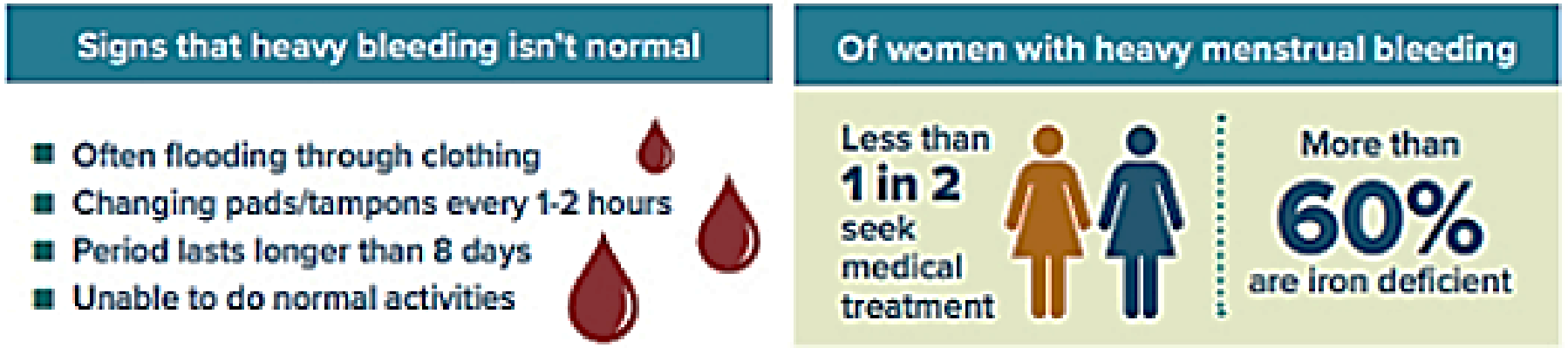
About abnormal vaginal bleeding (AVB)

About abnormal vaginal bleeding (AVB)

AVB is bleeding that is abnormal in duration, volume, or frequency, including:

- Heavy menstrual bleeding (previously called menorrhagia) – excessive menstrual blood loss which interferes with the patient's physical, emotional, social and material quality of life. This is the most common type of AVB.
- Intermenstrual bleeding (previously called metrorrhagia) – vaginal bleeding at any time other than during normal menstruation or following intercourse.
- Postcoital bleeding – bleeding following intercourse.
- Postmenopausal bleeding – vaginal bleeding after > 12 months of amenorrhoea.

Assessment:



- Hx and nature of bleeding (menstrual history - duration, heaviness and pattern)
- ? Associated dysmenorrhoea, dyspareunia, discharge/itch/dryness/dysuria
- Impact on quality of life
- Comorbidity especially presence of anaemia, STI risk
- Family History: bleeding disorders, endometriosis, endometrial or colorectal cancer
- Consider systemic causes e.g., hypothyroidism, PMOS, bleeding disorders
- Symptoms suggestive of structural or histological abnormality (including intermenstrual and postcoital bleeding, pain and pressure)
- Desire for more pregnancies, parity, history of C/S
- Contraceptive, IUD or MHT use, Tamoxifen use
- Other medication use
- Cervical Screening History/ HPV vaccination status

HEAVY PERIODS ARE COMMON - Approximately 1/4 women affected at some time in their life, but > 1/2 do not seek medical care worldwide (believe HMB is a normal part of having periods).

Peak incidences – adolescence and in 5th decade of life.

Approximately 25% of Australian adolescent girls report significant menstrual issues which interfere with their life and schooling.

Consider advising the patient to use a menstrual diary (printable version) or period tracker app

Menstrual / Pain Diary

Month ……………………

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Menstrual Flow (see box 1)																															
Pain (see box 2)																															

Month ……………………

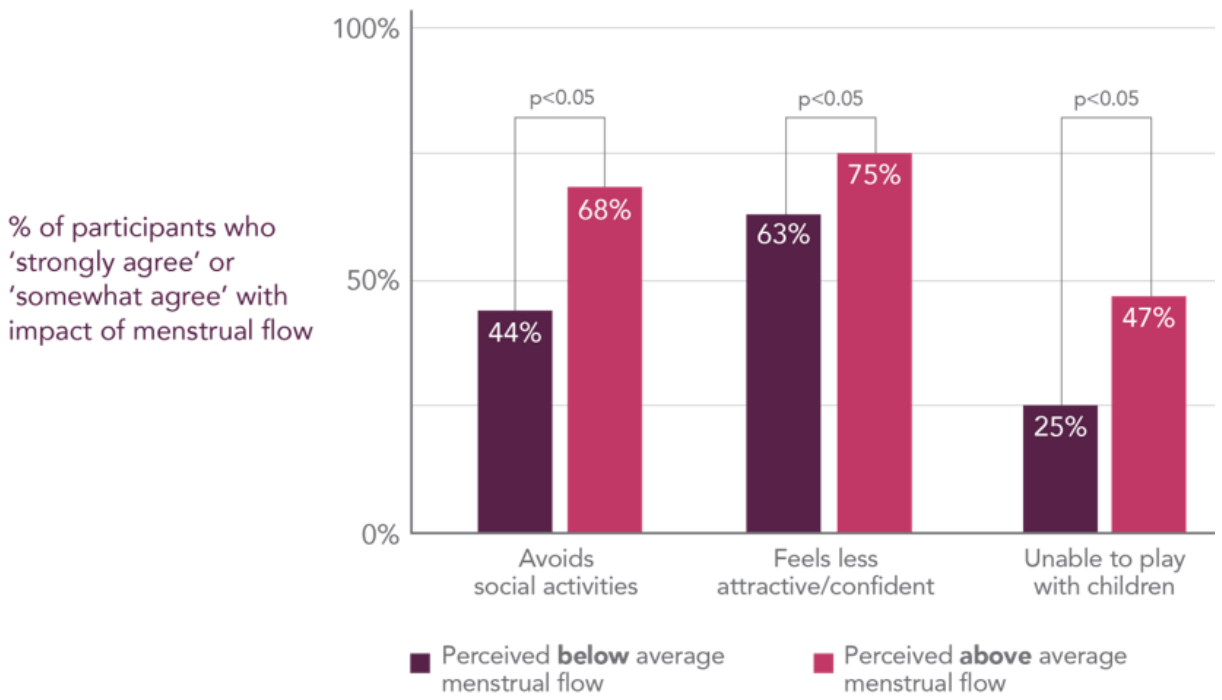
Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Menstrual Flow (see box 1)																															
Pain (see box 2)																															

Month ……………………

Day	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Menstrual Flow (see box 1)																															
Pain (see box 2)																															

Box 1	Box 2
Pain: +++ Severe: Requiring strong painkillers. Not able to do normal activities. ++Moderate: Needing mild painkillers but can carry on normal activities. + Mild: But not needing painkillers.	Menstrual flow +++ Heavy: Large clots and/or flooding. Needing sanitary towel as well as tampons. Makes you house bound. ++Moderate: Regular changes of towels or tampons. No social inconvenience. + Light: Need some protection to prevent staining of underwear. S: Spotting

HMB impacts on Social Lives, Relationships, Work and Daily Activities



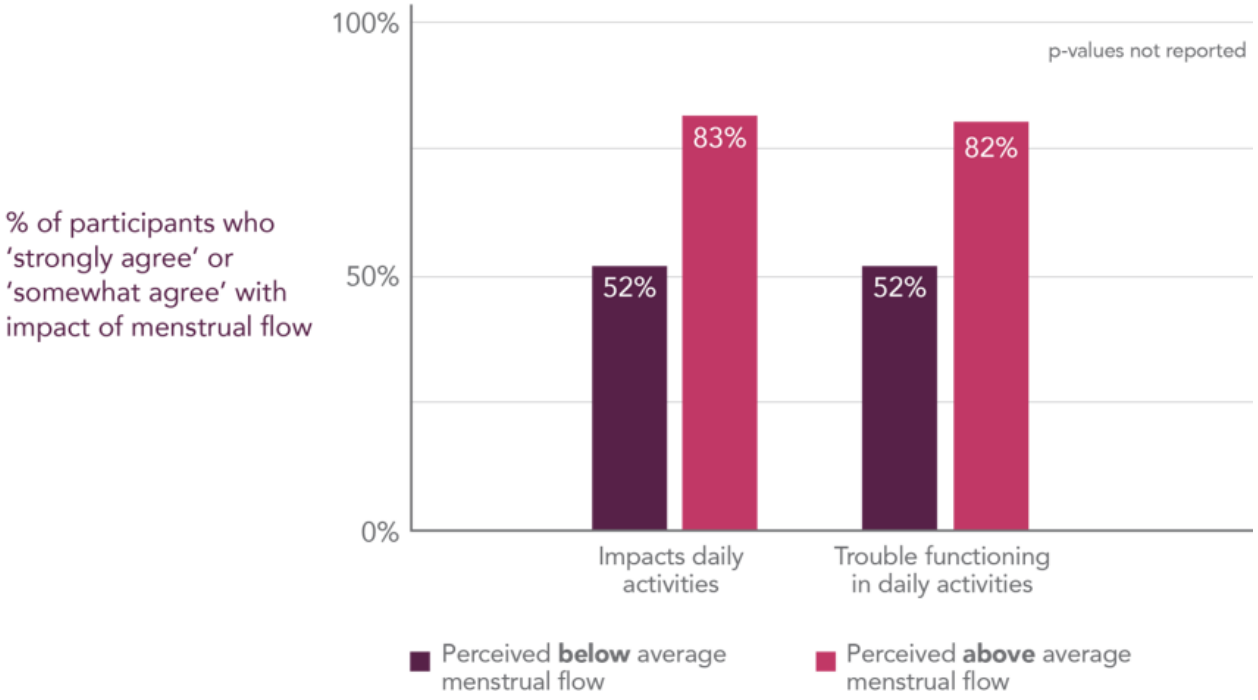


Figure adapted from Bitzer J *et al.* 2013.[1] Feelings on the implications of menstrual flow, in women who perceived their menstrual flow to be above average (n=1,627) or below average (n=4,227).

References: 1. Bitzer J *et al. Open Access J Contraception* 2013:4 21–8. 2. Australian Commission on Safety and Quality in Healthcare. Heavy Menstrual Bleeding Clinical Care Standard, June 2024. Available at: https://www.safetyandquality.gov.au/standards/clinical-care-standards/heavy-menstrual-bleeding-clinical-care-standard. Accessed May 2025. 3. Shapley M *et al. Br J Gen Pract* 2004;54:359–63.

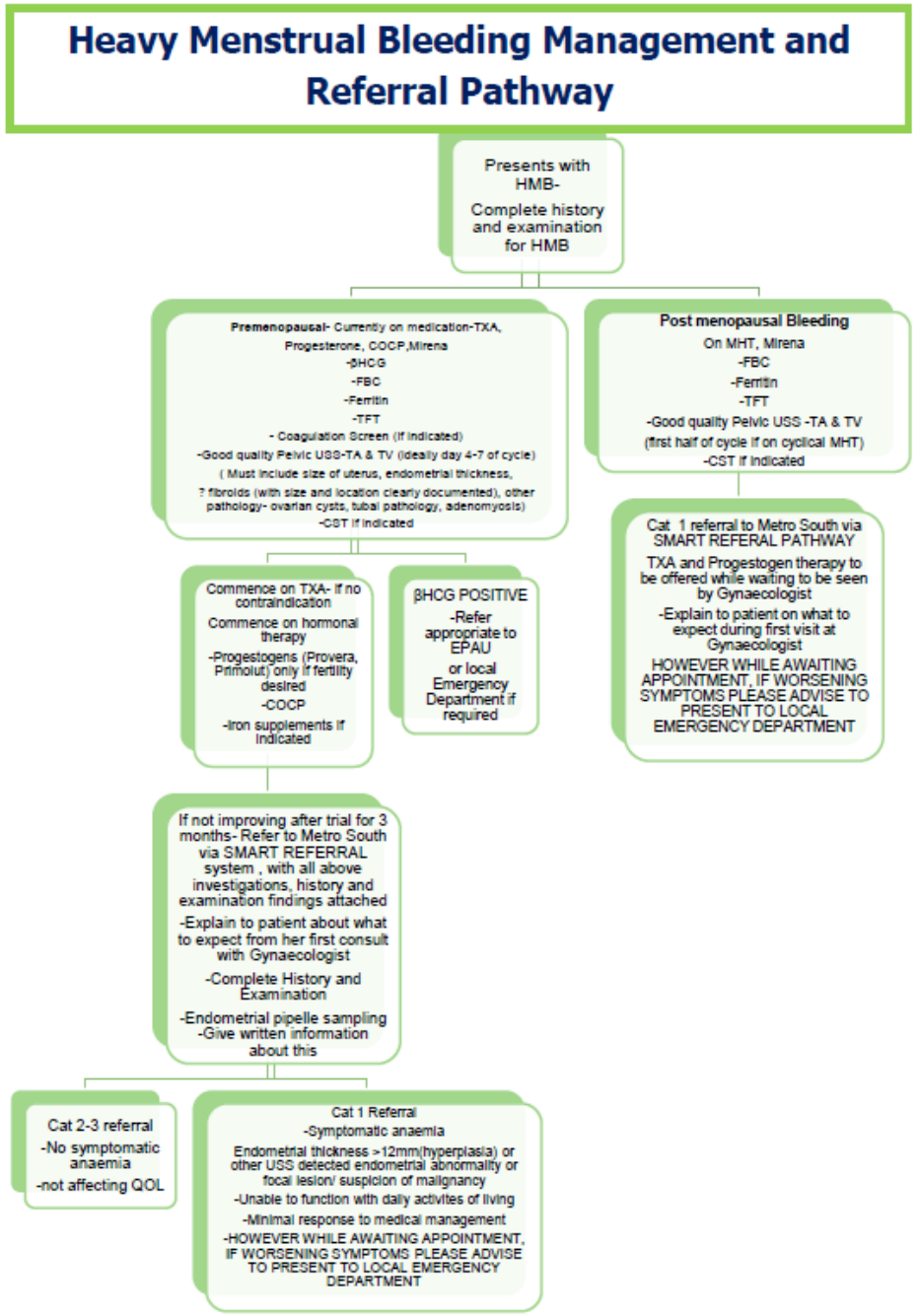
Examine the patient:

- Measure vital signs – temperature, pulse, blood pressure (sitting and standing)
- Skin – pallor, petechiae, bruising, acne, hirsutism, acanthosis nigricans
- Document BMI, and ask re recent gain or loss of weight
- Check for signs of anaemia - skin and conjunctival pallor.
- Consider thyroid examination
- Perform abdominal and bimanual pelvic examination, unless the patient has never had vaginal intercourse (checking for abnormal uterine size or palpable pelvic mass). Consider a chaperone.

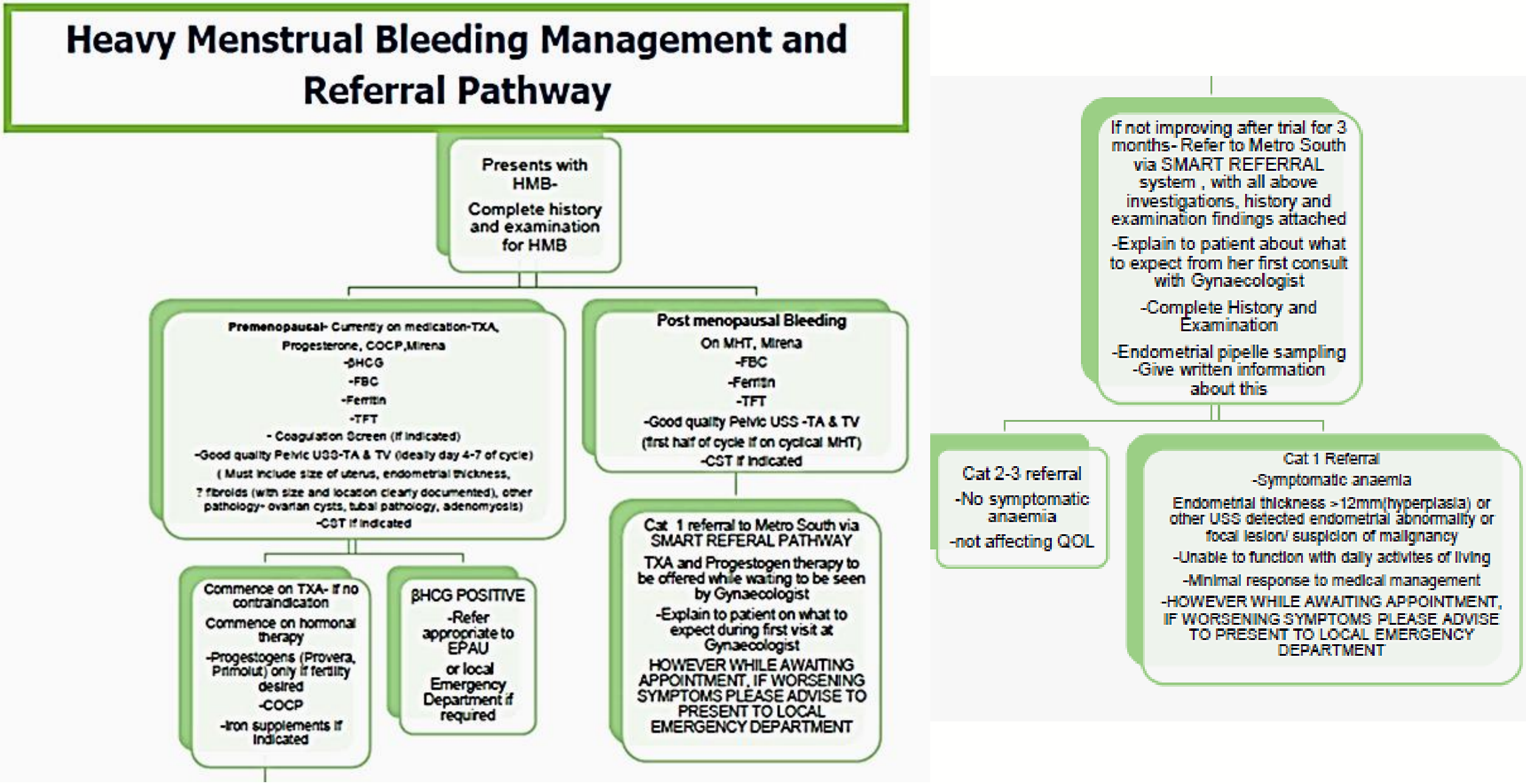
Investigations:

- Cervical co-test (HPV + LBC) if eligible
- FBC, iron studies/ferritin, TSH (+/- T4)
- Consider βHCG, Coagulation profile*, FSH, STI testing
- Pelvic/preferably transvaginal USS (day 4-7 ideally or in first half of cycle if on cyclical MHT), should describe:
  - size of uterus
  - endometrial thickness
  - fibroid size and position if present
  - ? ovarian or tubal pathology, ? adenomyosis
- Role for endometrial sampling?
- Role for D&C, hysteroscopy?
- In Adolescents: Von Willebrand Screen, APTT, PT, fibrinogen, platelet count (if bleeding disorder suspected , consider platelet function analysis) - Up to 30% adolescents with HMB have bleeding disorder, can coexist with anovulation.
- Avoid VWS during acute heavy bleeding presentation (wait for 6-8/52) & cease NSAID for at least 1/52 prior.

MSH Heavy Menstrual Bleeding Management and Referral Pathway



Heavy Menstrual Bleeding Management and Referral Pathway



What Causes HMB?

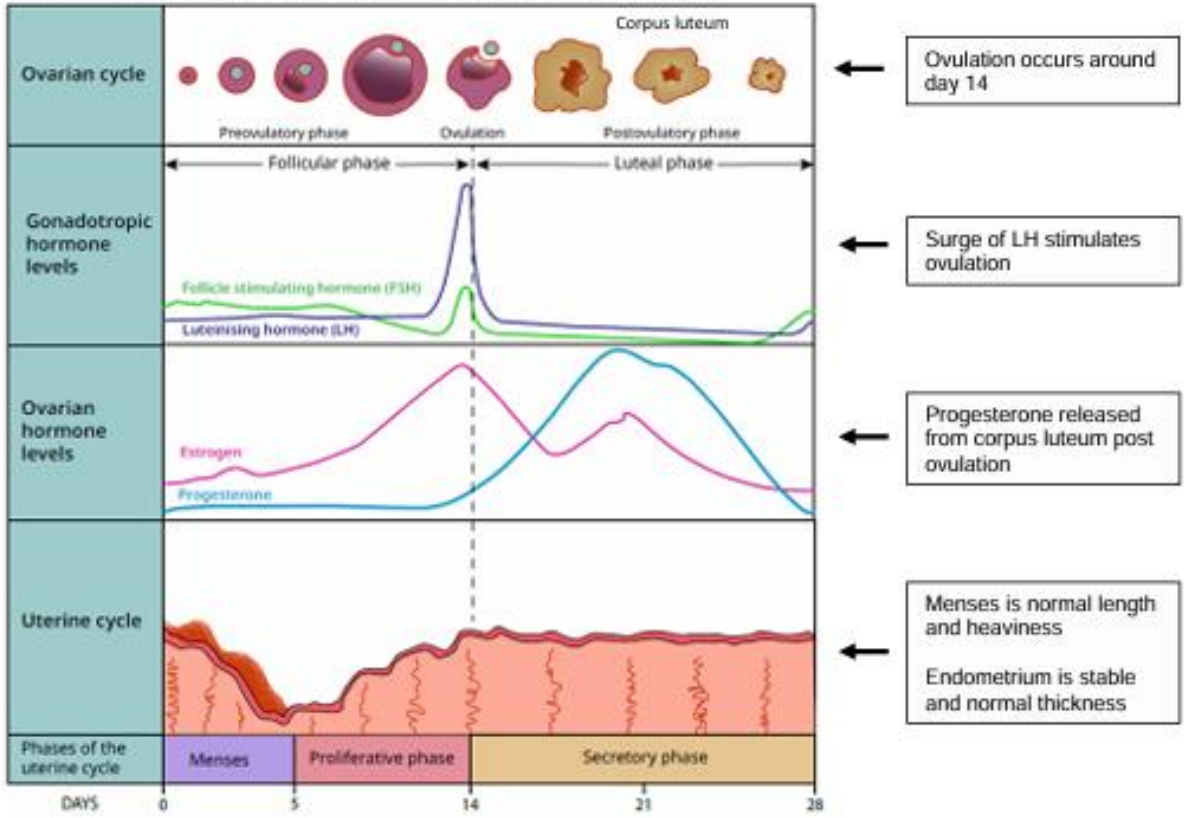
IDENTIFYING A CAUSE FOR HMB has been historically difficult, due to:

- Confusing and inconsistent nomenclature
- Lack of standardised approach to investigation and categorisation of potential aetiologies
- **40-60%of HMB has no underlying structural or histological cause**

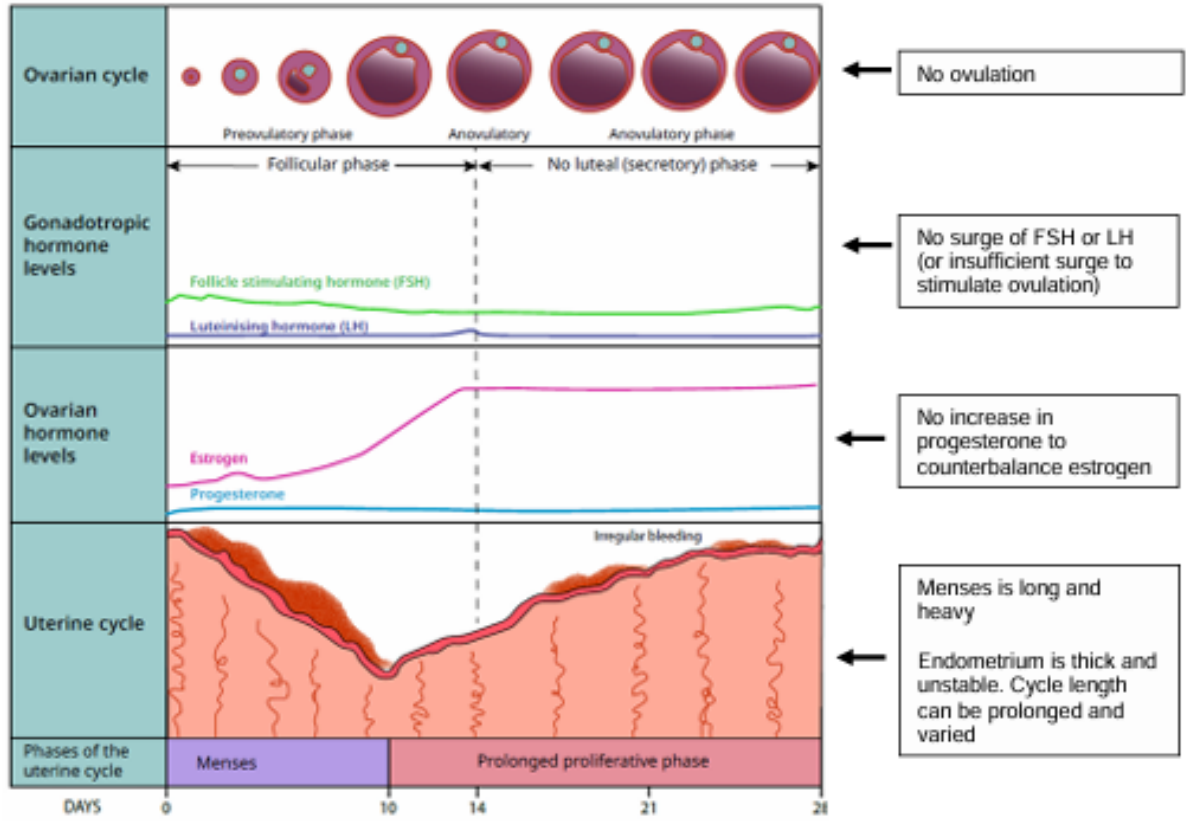
- Can be anovulatory or ovulatory in premenopausal women

Ovulatory vs Anovulatory Cycles

Appendix A: Normal ovulatory menstrual cycle



Appendix B: Anovulatory menstrual cycle



Anovulation can be important in adolescent and perimenopausal women.
In the first year following menarche, 50% adolescents have anovulatory cycles; by 2–3 years post menarche, 75% of adolescents are ovulating regularly; can take up to 8 years for full gynaecological maturation post menarche.

PALM-COEIN - FIGO Classification

Polyp
Adenomyosis
Leiomyoma
Malignancy and Hyperplasia

STRUCTURAL - can be identified /measured by imaging +/- histopathology

Coagulopathy
Ovulatory dysfunction
Endometrial
Iatrogenic
Not otherwise classified

NON- STRUCTURAL cannot defined by imaging or histopathology

FIGO classification system (PALM-COEIN) for causes of abnormal uterine bleeding in nongravid women of reproductive age - International Journal of Gynecology and Obstetrics 113 (2011) 3-13

https://obgyn.onlinelibrary.wiley.com/doi/10.1016/j.ijgo.2010.11.011

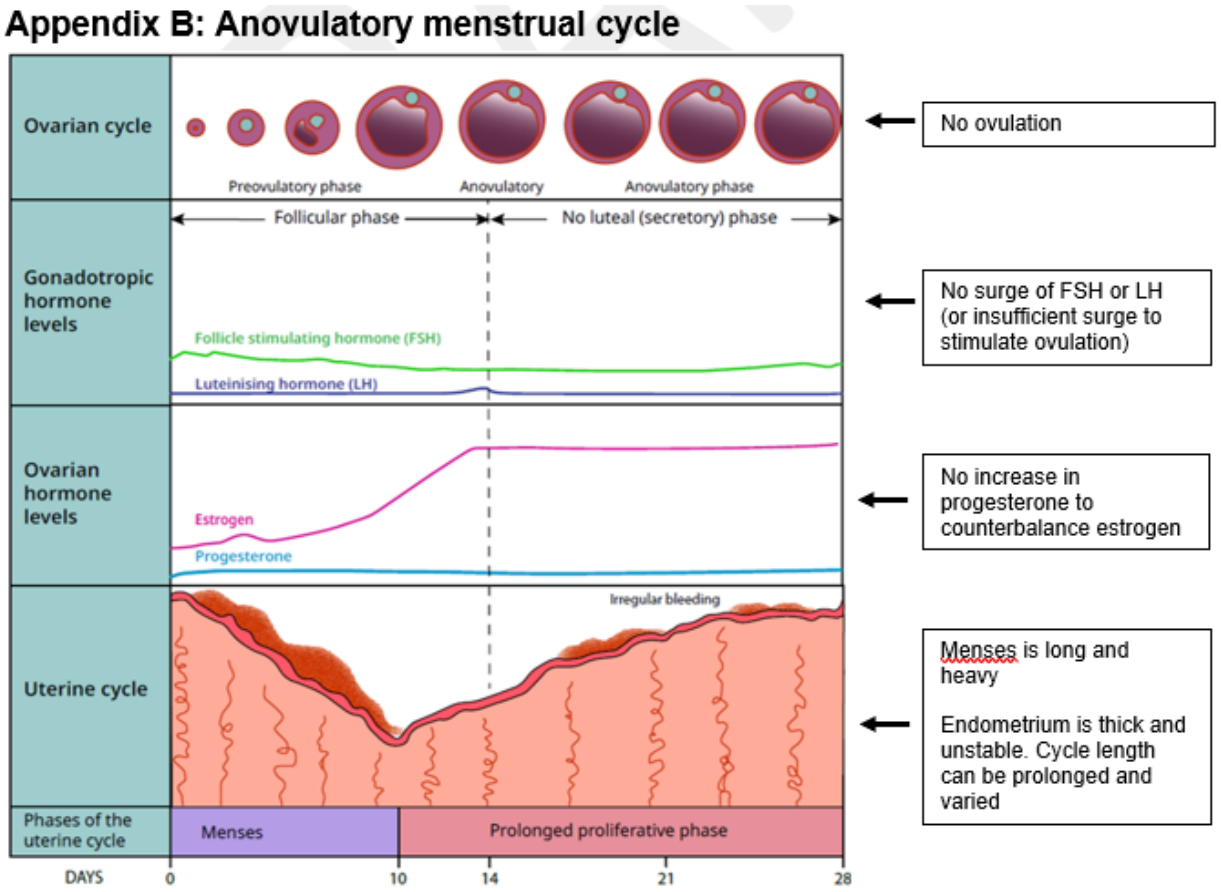
Risk Factors for Endometrial Cancer

- Age ≥ 45 years
- Early menarche
- Nulliparity
- Late menopause – after age 55 years
- Exposure to unopposed estrogen, including bio-identical hormones
- Tamoxifen use (current or past exposure)
- Chronic anovulation e.g., polyendocrine metabolic ovarian syndrome(PMOS)
- Intermenstrual bleeding (IMB) or postcoital bleeding (PCB)
- BMI ≥ 30
- Diabetes, Hypertension (Metabolic Syndrome)
- Immunosuppression
- Estrogen-secreting tumour
- Personal history or strong family history of breast, ovarian, endometrial or bowel cancer, especially Lynch syndrome
- Increased endometrium thickness (for menopausal status)

Anovulatory Bleeding:

Suspect if:

- irregular bleeding.
- aged < 20 years or > 45 years.
- Polyendocrine metabolic ovarian syndrome (PMOS).
- eating disorders.
- BMI < 20 or > 35.
- heavy exercise.
- uncontrolled diabetes mellitus.

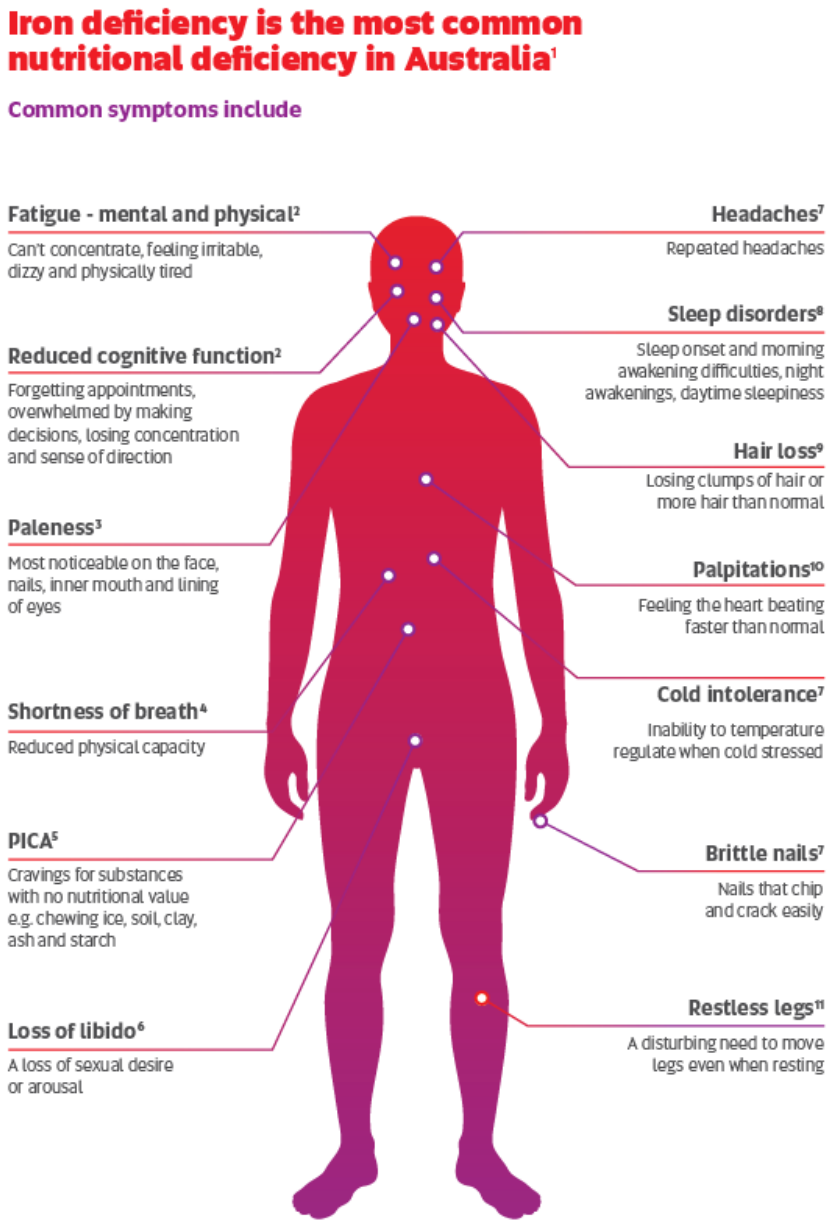


Menstrual Management in Children and Adolescents (Queensland Clinical Guidelines)

Treat the Iron deficit as a priority:

- Commence oral iron supplement and encourage iron rich diet
- REMEMBER:
  - Vitamin C enhances non-haem iron absorption
  - Calcium inhibits both haem and non-haem iron
  - Tea and coffee may reduce oral iron absorption
- Qld Health NEMO (Nutritional Educational Materials Online) information re Iron - Iron (health.qld.gov.au)
- Avoid IM iron injection if possible – poor absorption, painful to administer and staining risk
- Consider iron infusion – private if available (see Intravenous Iron Infusion - Community HealthPathways Brisbane South (SpotOnHealth)
- OR consider GP to GP Referrals - Community HealthPathways Brisbane South (SpotOnHealth) if unable to arrange at your practice

- Public capacity for iron infusion is limited and wait times can be long (likely at least Cat 2+ unless severely symptomatic)



GP to GP Referrals

About GP to GP Referrals

This page lists general practitioners offering services to other GPs' patients without obligation to continue care. The service is provided and the patient is returned to the referring GP for follow-up.

- Brisbane South HealthPathways does not provide any assurance of quality and will not provide governance to any of the services. See Disclaimer for private providers
- It is the responsibility of the referring GP to ensure that their preferred provider has the qualifications, experience, knowledge and skills to provide the care required [1].
- Brisbane South HealthPathways assumes that clinical practice, including clinical handover, is guided by professional standards and guidelines.
- The service provider must inform Brisbane South HealthPathways of any changes in their details. Failure to do this will result in deletion of the record.

Service providers

Complete the listing request online or by downloading and returning the pdf request form if you would like to be included in the lists of general practitioners who take referrals for the following procedures.

- Contraception – see Children by Choice provider information.
  - Implanon removal and insertion
  - IUD removal and insertion
  - Vasectomy
- Ear toilet or microsuction
- Eyelid lesion excision
- Ferinject Iron Infusion
- Hepatitis C experienced prescribers
- S100 prescriber (listings are managed by Queensland Health)
- Skin lesion excision
- Termination of pregnancy

[GP to GP Referrals - Community HealthPathways Brisbane South (SpotOnHealth)]

Ferinject iron infusion therapy

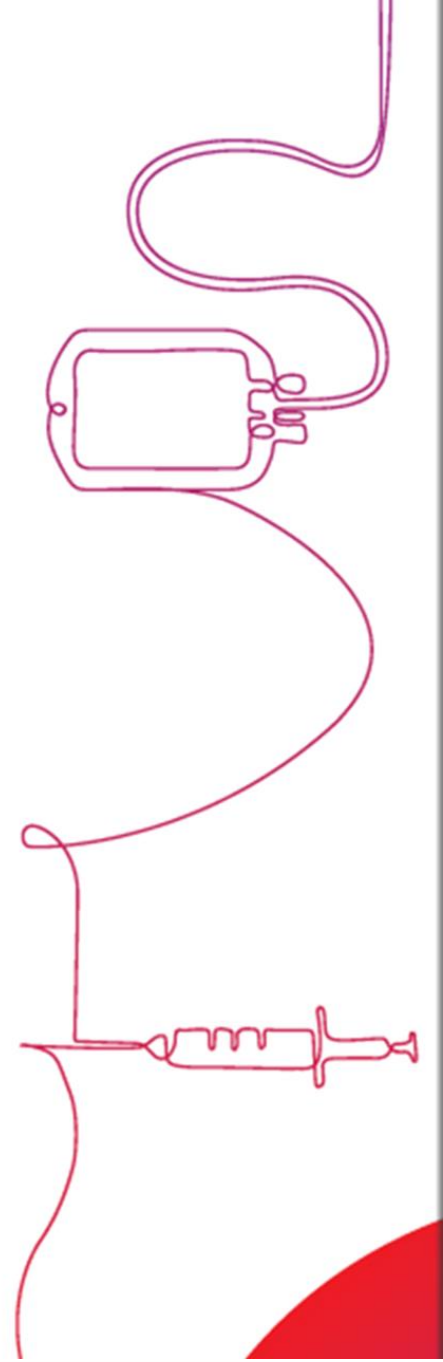
See the relevant pathway for details – Intravenous Iron Infusion

- Beenleigh
- Browns Plains
- Camp Hill
- Capalaba
- Carina
- Carindale
- Cleveland
- Coorparoo
- Forest Lake
- Gumdale
- Highgate Hill
- Jimboomba
- Kangaroo Point
- Kingston
- Logan Central
- Loganholme
- Manly West
- Moorooka
- Morningside
- Rochedale
- Sinnamon Park
- Springwood
- Sunnybank Hills
- Tamborine
- Tingalpa
- Underwood
- Victoria Point
- West End
- Woodridge

When might oral iron not be appropriate?[17,18,19]

Oral iron therapy is suitable and effective as first line therapy in most patients with iron deficiency or iron deficiency anaemia. Potential situations where IV iron may be appropriate, subject to clinical discretion include:

- Unsuccessful oral therapy – lack of response, poor adherence, intolerance
- Malabsorption (e.g. coeliac disease, bariatric surgery)
- Clinically active inflammatory bowel disease
- Chronic kidney disease receiving erythropoiesis- stimulating drugs
- Rapid increase in iron required (e.g. pre-operatively for urgent surgery or following acute blood loss)
- Heart failure
- Pregnancy (beyond the first trimester) and postpartum if oral iron not suitable or effective, or to prevent physiological decompensation
- Comorbidities which may impact on absorption (e.g. Intestinal mucosal disorders), or bone marrow response
- Ongoing iron losses that exceed absorptive capacity



From “Ferinject” (Ferric Carboxymaltose) Brochure

Heavy Menstrual Bleeding Clinical Care Standard
The Revised Standard was published in early 2024.

Eight quality statements that describe the expected care for women with HMB:

1. **Assessment and diagnosis**
2. **Informed choice and shared decision making**
3. **Initiating medical management**
4. **Quality ultrasound**
5. **Intrauterine hormonal devices**
6. **Specialist referral**
7. **Uterine-preserving alternatives to hysterectomy**
8. **Hysterectomy**

https://www.safetyandquality.gov.au/standards/clinical-care-standards/heavy-menstrual-bleeding-clinical-care-standard Accessed July 2025

Treatment Options:

Pharmacological Rx –

- correct iron deficiency
- tranexamic acid (TXA)
- NSAIDs
- COCP/cyclical oral progesterone/ DMPA
- LNG-IUS, ulipristal acetate
  or GnRH analogues if fibroids (including Ryego)

Surgical Rx -

- endometrial ablation
- hysteroscopic removal of polyps/fibroids
- myomectomy, uterine artery embolization
- hysterectomy

Medical management of acute heavy bleeding

Consider medication contraindications, including thromboembolism risk, before prescribing.

1. First line – oral tranexamic acid 1 to 1.5 g every six to eight hours until bleeding stops.

2. Second line:
    - Oral high dose progestogens every 4 hours until bleeding stops, e.g.:
        - norethisterone 5 to 10 mg.
        - medroxyprogesterone 10 -20mg (maximum dose 80 mg per day).
    - Stopping medication – once bleeding stops, stagger slow reduction over 2 - 3 weeks, i.e. reduce dose every few days until stopped. Stopping progesterone too quickly will trigger a repeat bleed.

3. Third line:
    - Combined hormonal contraceptives (containing at least 50 microgram ethinylestradiol) every 6 hours until bleeding stops. Re-evaluate after 48 hours.
    - Antiemetics may be required with high dose hormone treatment.

Abnormal Vaginal Bleeding - Community HealthPathways Brisbane South (SpotOnHealth)

Ongoing management of menorrhagia – medical

If normal investigations and no risk factors for malignancy (or contraception required) - can prescribe long-term medical treatment:

Non-hormonal treatments - more effective if bleeding is cyclic, or its timing predictable:

1. Tranexamic acid – 1 to 1.5 g orally, 3 or 4 times daily for the first 3 to 5 days, can reduce flow by 25-50%, inhibits clot dissolving enzymes in the endometrium
2. NSAIDs e.g., mefenamic acid, ibuprofen or naproxen – can reduce flow by 20-30% and use with TXA
3. Advise patient to:
    - Start just before, or at the earliest onset of, menses.
    - Continue regularly for the first 3 to 5 days of the cycle.
4. Important to start these early and continue at therapeutic dose.

Ongoing management of menorrhagia – medical

Hormonal treatment options

1. Levonorgestrel IUD – if long-term use (at least 12 months) is anticipated
2. Combined oral contraceptive pill (COCP) – tri-cyclical or continuous use, can reduce flow 40-60%
3. Injected long-acting progestogens – depot medroxyprogesterone acetate (e.g., Depo-Provera)
4. Oral progestogens (**non-contraceptive**) – norethisterone or medroxyprogesterone acetate
   Avoid > 6/12 use due to risk hypoestrogenism, can reduce flow by 30-90%
   OR if contraception needed, consider Slinda (drospirenone) 4mg daily

If persistent HMB despite maximal medical therapy, consider repeat TV USS and request further gynaecology assessment.

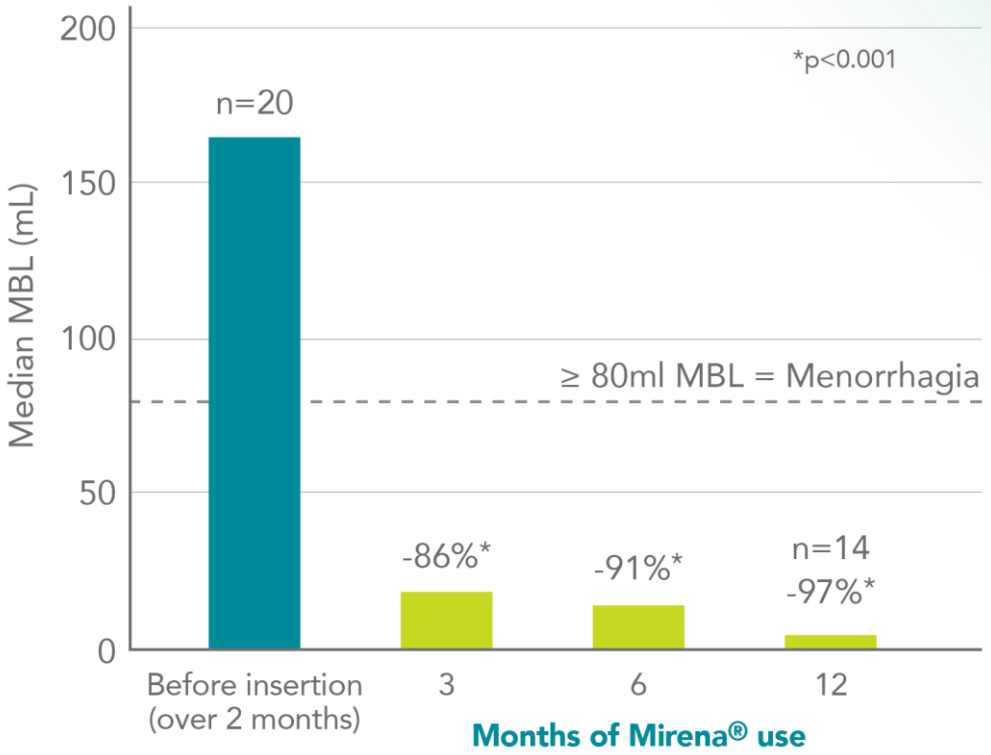
Anovulatory Bleeding – use for same 12 /7 monthly	Ovulatory - Regular Heavy Bleeding
Norethisterone 5mg daily or bd	Norethisterone 5 mg tds from days 5 to 26 (of a 28-day cycle).
Medroxyprogesterone 5-10mg daily	Medroxyprogesterone 10-20 mg 1-3 times daily - day 1 to 21
•Micronised progesterone 200 - 300 mg orally nocte	If spotting occurs, increase dose and if spotting stops and patient has progestogenic side-effects (e.g., headaches, weight gain, bloating, mood changes, acne), consider reducing back to starting dose.

Hormonal therapies for paediatric and adolescent patients - progesterone-only preferred for HMB related pain, as helps to counter unopposed estrogen and ? prevents retrograde menstruation and development of endometriosis.

MIRENA® FOR HMB

*"[Mirena is] an **effective method** of treatment for heavy menstrual bleeding and is particularly suitable for women who require contraceptive protection and wish to preserve their fertility"*[1]

- Mirena can be used successfully in the treatment of idiopathic menorrhagia[2]
- An overall reduction in menstrual blood loss of approximately 93%[2] may also result in increased ferritin and haemoglobin[3]



Open label study. 20 women (mean age 38; range 31-45) with menstrual blood loss measured at >80 mL per cycle during 2 consecutive cycles prior to treatment. MBL, menstrual blood loss. Adapted from Andersson *et al.* 1990.[3,4]

References: 1. Roy SN and Bhattacharya S. *Drug Safety* 2004; 27(2):75-90. 2. Mirena® Approved Product Information, June 2024. 3. Mirena Product Monograph; 8th Edition. 4. Andersson *et al. Br J Obstet Gynaecol* 1990;97(8):690-4.

MIRENA® SAFETY INFORMATION

Contraindications[1]

Mirena® is contraindicated in patients with:

- known or suspected pregnancy
- current or recurrent pelvic inflammatory disease
- lower genital tract infection
- postpartum endometritis
- infected abortion during the past three months
- cervicitis
- cervical dysplasia
- uterine or cervical malignancy
- confirmed or suspected hormone-dependent tumours, including breast cancer
- undiagnosed abnormal uterine bleeding
- congenital or acquired uterine anomaly, including fibroids if they distort the uterine cavity
- conditions associated with increased susceptibility to infections
- acute liver disease or liver tumour
- hypersensitivity to the active substance or any of the excipients.

Special warnings and precautions[1]

Mirena® may be used with caution after specialist consultation, or removal of the system should be considered if any of the following conditions exist or arise for the first time:

- migraine, focal migraine with asymmetrical visual loss or other symptoms indicating transient cerebral ischaemia.
- exceptionally severe headache
- jaundice
- marked increase in blood pressure
- severe arterial disease such as stroke or myocardial infarction
- acute venous thromboembolism.

Reference: 1. Mirena® Approved Product Information, June 2024.

SLINDA – drospirenone – now on PBS

- Slinda, a progestogen-only oral contraceptive pill, can be an effective option for managing heavy menstrual bleeding.
- It works by suppressing ovulation, thickening cervical mucus, and thinning the uterine lining, which can lead to lighter and potentially less frequent periods or even amenorrhea (absence of periods) for some women.

- How Slinda helps with heavy periods:
  - **Reduces Menstrual Flow:** Thins uterine lining ; can significantly reduce the amount of menstrual blood loss
  - **Regulates Bleeding Patterns:** Some women may experience irregular bleeding, especially in initial months, but many find that Slinda helps establish a more predictable and manageable menstrual cycle, with some even experiencing no bleeding at all.
  - **Potential for Lighter or No Periods:** Drospirenone can decrease menstrual flow, and some women may find they have very light periods or no periods at all after a few months of use.
- Dose 4mg daily 24 days per cycle with 4 placebo tablets/cycle
- May not be adequate for full menstrual suppression

RYEQO®

- Hormone based oral medication with 3 ingredients - can be used to alleviate fibroid related heavy menstrual bleeding.
- Contains:
  - GnRH analogue Relugolix, which inhibits release of pituitary stimulating hormones, thus reduces oestrogen and progesterone production from ovaries.
  - second ingredient is an oestrogen to alleviate menopause-like symptoms and prevent osteoporosis.
  - third ingredient is a progestogen to protect the endometrium

- Effective for reducing menstrual bleeding - 50% women will not have a period after about 6-months treatment but needs to be taken daily and indefinitely to maintain symptom control.
- Common side effects are hot flushes, headache and raised blood pressure.
- Ryeqo **not** on PBS yet (for fibroids): cost estimated $135 per month.

- However, trial studies showed an insignificant fibroid volume loss of only 12% at 6 months. The drug is far less effective in shrinking fibroids comparing with UFE (uterine fibroid embolization), which on average will shrink fibroid volume by 60% at 6 months.

Referral

EMERGENCY DEPARTMENT REFERRAL – for URGENT Specialist Assessment if

- significant uncontrolled bleeding.
- haemodynamic instability.
- ectopic pregnancy

Outpatients Referral or Private Gynaecology Opinion if:

- malignancy suspected or significant risk factors for malignancy
- anaemia and Hb < 85 g/L, or transfusion is required
- **endometrial thickness** (transvaginal ultrasound, ideally performed on day 4 to 7 of patient's cycle)
  - premenopause > 12mm
  - perimenopause > 5mm
  - postmenopause > 4mm
- irregular endometrium or focal lesion or large fibroid
- associated post-coital (or intermenstrual) bleeding and concerns re appearance of cervix, vagina or vulva
- cervical polyp
- If medical management not suitable or patient fails to respond

Potential treatments for heavy menstrual bleeding

Medicines	Procedures that preserve the uterus	Hysterectomy (surgery to remove the uterus)
NON-HORMONAL Anti-inflammatories Tranexamic acid	**ENDOMETRIAL ABLATION** Procedure to remove uterus lining using heat	**LAPAROSCOPIC** Keyhole surgery via the abdomen *(less invasive)*
HORMONAL e.g. Combined oral contraceptives Oral progestogens	**UTERINE ARTERY EMBOLISATION** Radiological procedure for fibroids	**VAGINAL** Surgery via the vagina *(less invasive)*
HORMONAL IUD 52 mg levonorgestrel-releasing intrauterine device	**HYSTEROSCOPIC RESECTION** Removal of polyps or fibroids	**ABDOMINAL** Major operation via the lower abdomen
	MYOMECTOMY Operation to remove fibroids	

Less invasive → **More invasive**

MadeHER: Origins and Impacts of Menstrual Disorders and Pelvic Pain – Research

At University of Queensland's Australian Women* and Girls'* Health Research Centre, research into how periods and pelvic pain impact the day-to-day lives of teenagers (11–19-year-old girls)

Why are we interested in periods?
Irregular, heavy, or **painful periods** and **pelvic pain** are both incredibly common and incredibly disruptive. Some research suggests as many as **1 in 3** female* students report **missing school** due to period symptoms, and **for 1 in 10 this happens every cycle**. The majority of these girls* felt their periods had an **impact on their performance in tests** and assignments and **reduced participation in sports** and physical activity. Missing out on these opportunities early in life results in long-term health, wellbeing, educational and financial **disadvantages later on**.

This type of data has **never been recorded in Australia before**, so we don't know the impact that periods and pelvic pain have girls' wellbeing.

The knowledge we gain from the MadeHer project, will **inform policy** and **guide health professionals** to **improve risk assessment**, **prevention**, **and management of period issues and pelvic pain**, as well as improve information materials for educators, teenagers, and their families.

Qld Clinical Guideline "Menstrual management in children and adolescents"

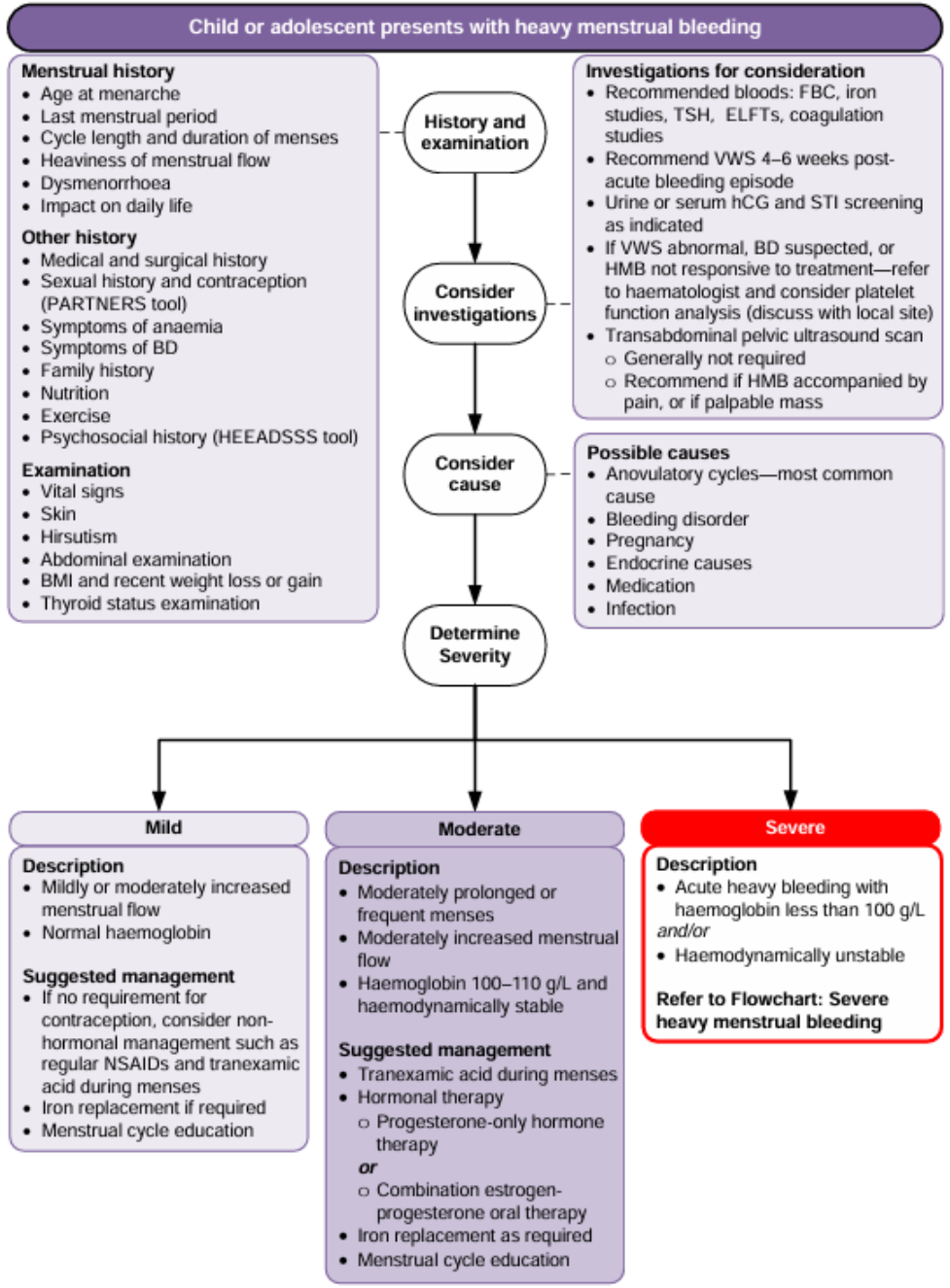
[Guideline: Menstrual management in children and adolescents]

Queensland Clinical Guidelines
Translating evidence into best clinical practice

Clinical Guideline

Menstrual management in children and adolescents

Flowchart: Heavy menstrual bleeding in adolescence



Period ImPact and Pain Assessment (PIPPA) Tool

Period Impact and Pain Assessment (PIPPA) tool -Canberra Endometriosis Centre.

- Questions relate to the impact that your period symptoms have on your life.
- If you are having period symptoms (like pain) that are bothering you, it's worth checking your PIPPA score to see if you should see your doctor.

Over the last six months have you:

1. had regular severe period pain?

2. had significant interference to your usual daily activities because of your period?

3. experienced bowel or bladder pain?

4. regularly missed school or work because of your period?

5. felt sure there is something wrong with your periods?

For each question you answer 'Yes' to = 1 point.

Parker M, Sneddon A, Arbon P. The menstrual disorder of teenagers (MDOT) study: determining typical menstrual patterns and menstrual disturbance in a large population-based study of Australian teenagers. BJOG: An International Journal of Obstetrics & Gynaecology 2010;117(2):185-92.

Previous research tells us just under 12% of young Australian women score a 4 or 5. The higher the score, the more likely it is that you could have an underlying issue (such as endometriosis) that is causing your symptoms. No website or tool (even PIPPA) can accurately diagnose endometriosis (or any other menstrual disorder). There may be absolutely nothing wrong, but your doctor is the best person to help determine the next steps. It's important to speak to your doctor sooner rather than later, as most research shows it often takes more than five years for women to get help, even when they have severe pain.

We suggest the following depending on your score:
1-2: Self Care Strategies after checking your PIPPA score
3 : Probably worth speaking to your doctor next time you see them, but self-care strategies discussed may help reduce impact of your symptoms.
4 or 5: Means your period pain (and other symptoms) have a pretty big impact on your life. This isn't something that is 'normal' or that you should ignore. We suggest you make an appointment to speak to your doctor in the near future. They will be able to investigate further and see if there is anything that might be causing these symptoms.
Even if you scored low on PIPPA, if you think something is wrong, speak to your doctor

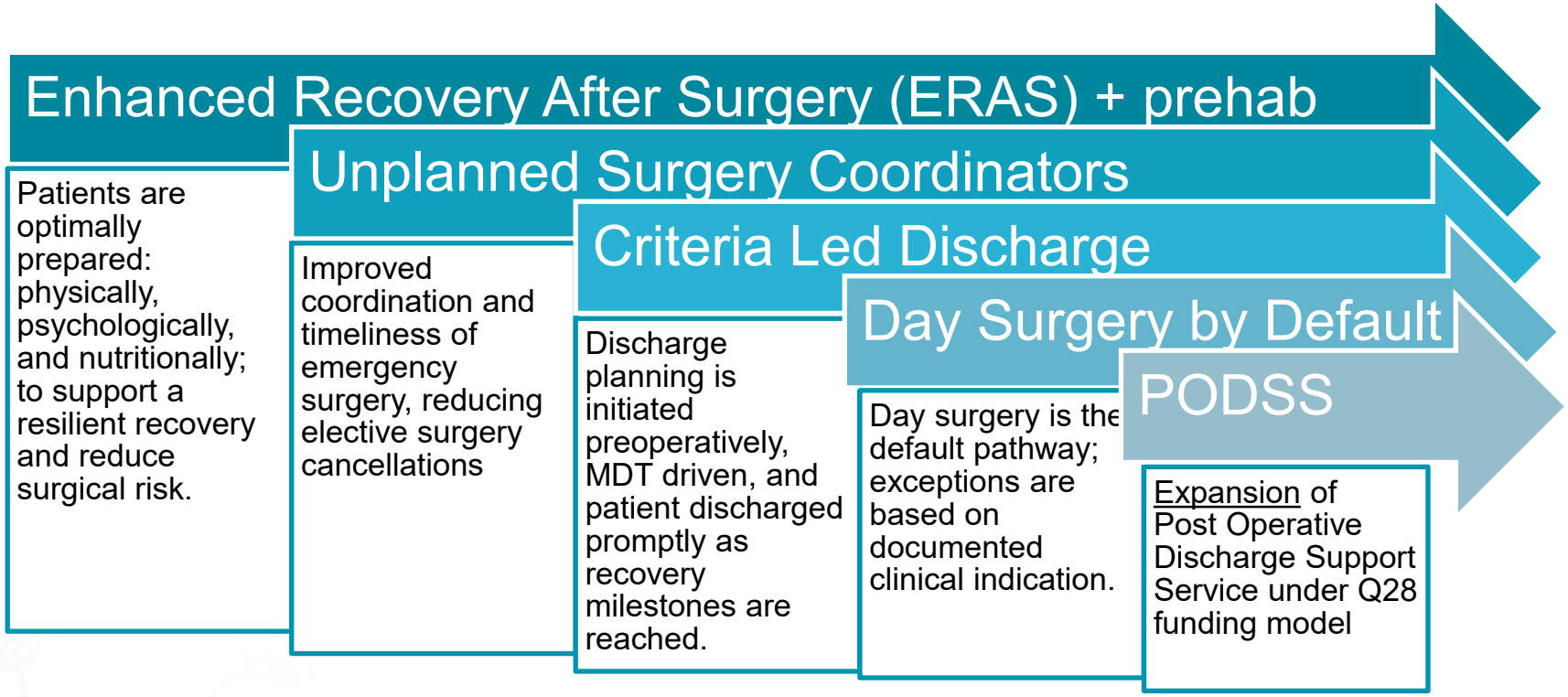
SurgiFlow

Elisha Conley

Acknowledgement of Country

Metro South Health recognises and pays respect to the Traditional Custodians of the land and waters – the Yugambeh, Quandamooka, Jaggera, Ugarapul, Turrbal, and Mununjali peoples – and to Elders, past and present.

What is SurgiFlow?

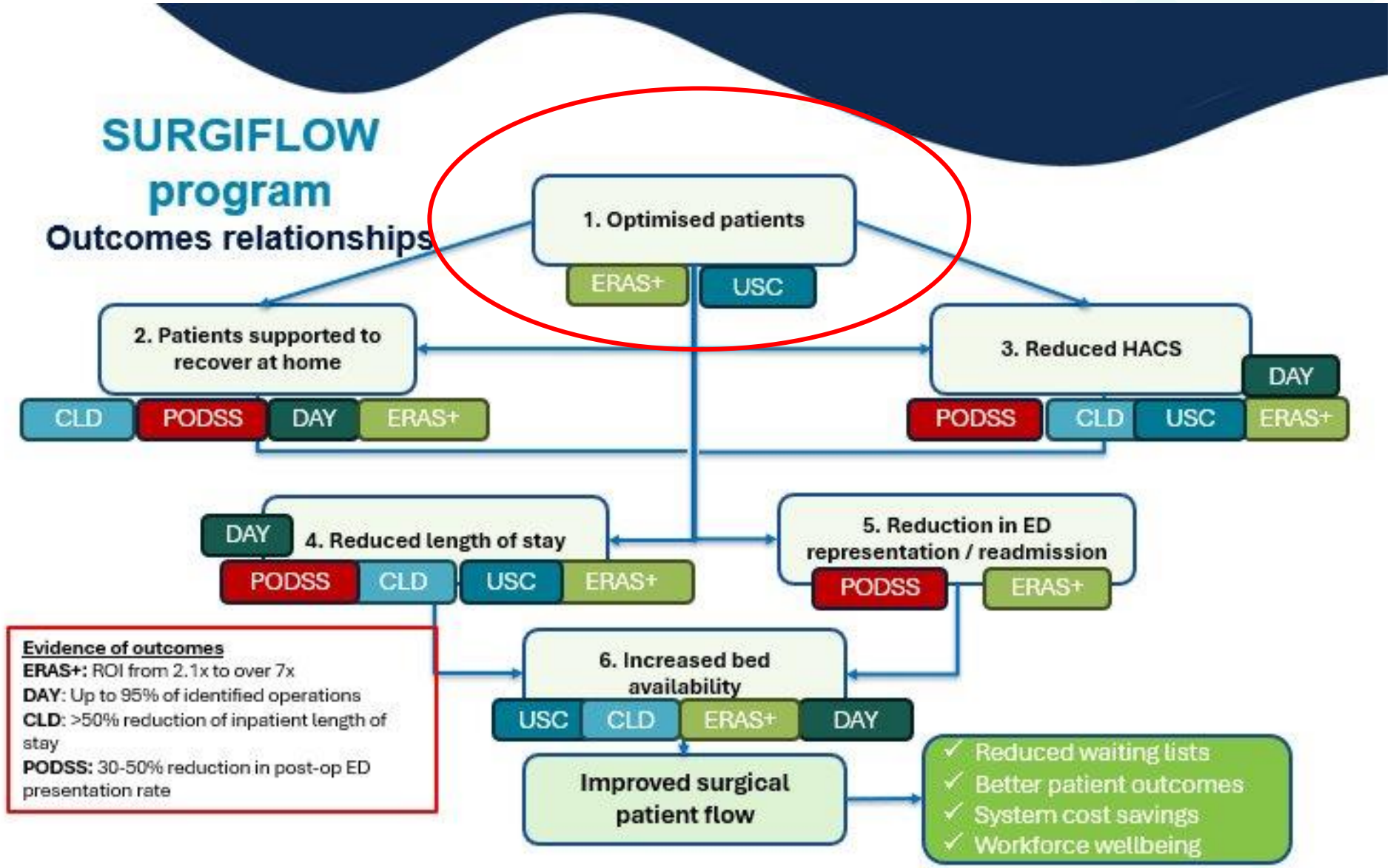


Priority DRG's

Specialty	DRG Code	DRG Description
Orthopaedics	I29Z	Knee Recon & Revision
Orthopaedics	I13C	Humerus, Tibia & Ankle minor complexity
Urology	L07B	Transurethral Procedures minor complexity
Gynaecology	N04B	Hysterectomy, minor complexity
Breast Surgery	J06B	Major Breast Procedures, minor complexity
Breast Surgery	J07Z	Minor Breast Procedures
ENT	D10Z	Nasal Procedures
ENT	D11Z	Tonsil and Adenoid Procedures
ENT	D06Z	Sinus and Middle Ear Procedures
General Surgery	H08B	Laparoscopic Cholecystectomy minor complexity
General Surgery	G10B	Inguinal, Femoral or Umbilical Hernia Procedures, minor complexity
General Surgery	K06B	Thyroid Procedures, minor complexity

ERAS pre-op

- Quitting or reducing smoking/vaping
- Reduce alcohol consumption
- Exercise and breathing exercises.
- Adequate nutrition
- Suitable accommodation and social supports



Diabetes - Who is having surgery, and what do we know?

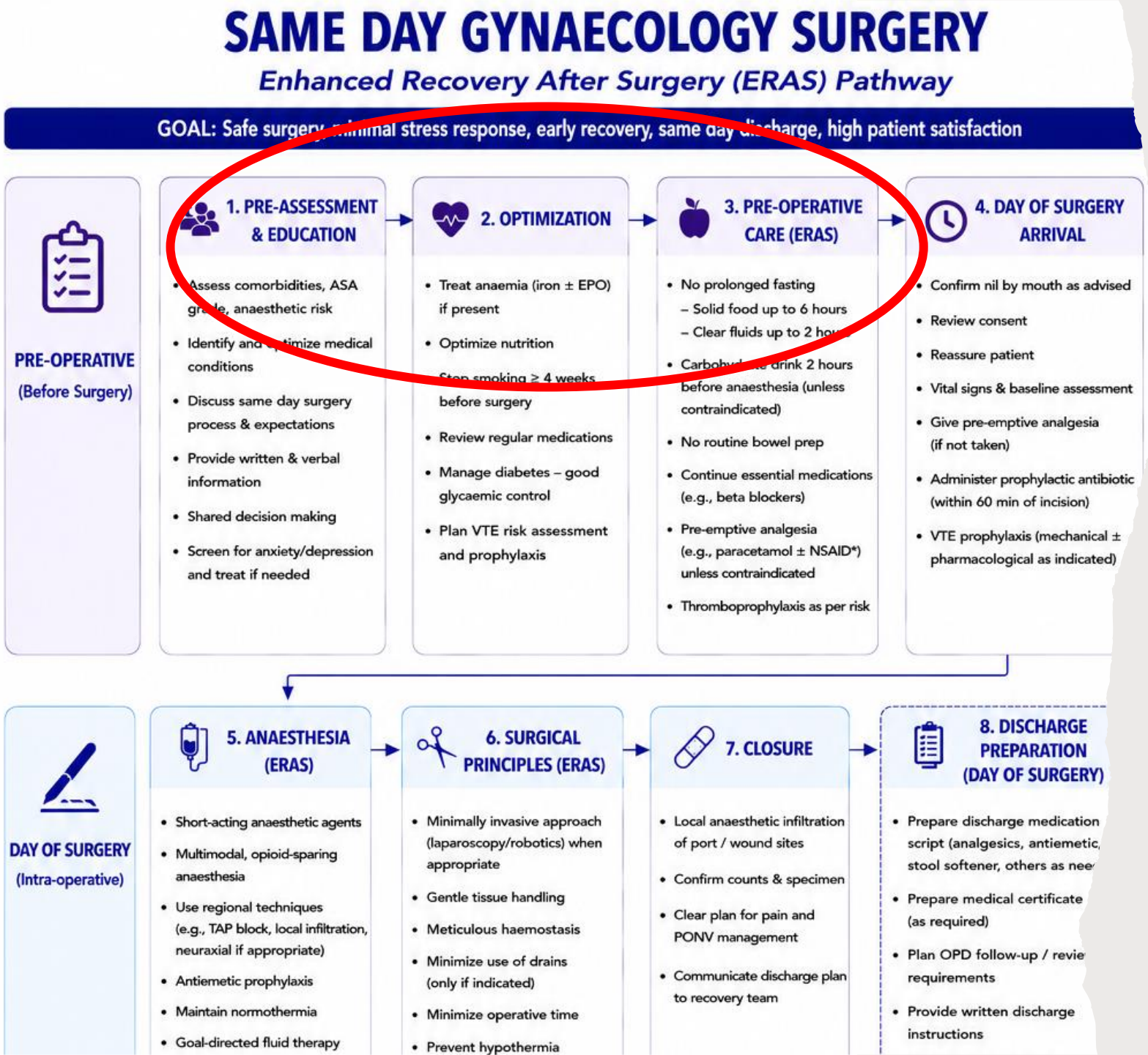
Measure	Value
Sites	7 (3 metro, 4 regional)
Total surgical patients sampled/audited	6,375 (12 months - 1/1/2025 – 31/12 2025)
Patients with known diabetes	835
Diabetes prevalence	13.1% *(≈ 1 in 8 patients having surgery have diabetes)*

Diabetes and surgery	N= 835	%
Planned surgery	473	56.5%
Urgent surgery	273	32.6%
Emergency surgery	91	10.9%
HbA1c recorded (planned surgery only)	155 / 473	32.9%

HbA1c not recorded prior to surgery - 67.1%

Current Gynaecology Day Surgery @ Logan Hospital

- Hysteroscopy
- Dilation and Curettage (D&C)
- Gynaecological Examinations
- Excision of skin lesions/soft tissue
- Endoscopic destruction of procedures on uterus
- Laparoscopic Oophorectomy
- Laparoscopy
- Large Loop excision of transformation zone (LLETZ)
- Ovarian Cystectomy
- Removal of IUD
- Removal of foreign body
- Laparoscopic Salpingectomy



Laparoscopic Hysterectomy

ERAS

UPDATES

Queensland Government | Queensland Health

Brisbane South Community HealthPathways

Service referrals

Clinical Prioritisation Criteria

Clinical decision support tools that will help ensure patients referred for public specialist outpatient services in Queensland are assessed in order of clinical urgency.

Morning Tea

Session 2

Time	Session name	Presenter	Delivery
10:30 am	Case Discussions – Pelvic Floor Prolapse and Urinary Incontinence	Group Spokesperson Dr Hasthika Ellepola	Facilitated groups Power Point Presentation & Forum Discussion
10:50 am	Physiotherapy Management of Prolapse, Urinary and Faecal incontinence; Physiotherapy Pelvic Health Service in MSHHS	Melanie Walkenhorst	Power Point Presentation & Forum Discussion
11:15 – 12:30pm	Hands-On Practical Demonstrations - Vaginal Pessaries - Implanon Insertion - IUD Insertion Simulator - Pipelle Biopsy Demo - Novasure/Myosure Demo	Breakout Group Rotations	Facilitated groups Power Point Presentation & Forum Discussion
12:30 pm	Wrap Up CPD Discussion	Dr Kim Nolan ALL	ALL

Purple Group Task

Donna is 52 years old. G4P3M1 - BMI 40 kg/m2

- Smoker
- Hypertension, COPD, anxiety/depression, chronic back pain

Urinary incontinence

- Has to “rush to the bathroom”
- “Leakage with coughing”
- No fever, no dysuria, no haematuria, no pelvic pain

Outline your approach

Red Group – Task

Helen is a healthy 43-year-old - BMI 33 kg/m2

- G2P2
  - 4200g forceps, episiotomy, 2nd degree tear
  - 3800g vaginal birth, episiotomy

- “Feels like something is bulging out”
  - Feeling of heaviness, dragging
  - Constipation
  - Feeling of incomplete emptying of bladder & bowel

Outline your approach

HISTORY

- **General**
  - Fluid intake – volume, timing, caffeine or alcohol containing
  - Past obstetric/gynae history
  - Past med/surg history
  - Medications
  - Weight/BMI
  - Bowel Habit
  - Smoking/Cough

- **Prolapse symptoms**
  - Vaginal bulge/dragging
  - Need to reduce to PU/BM

- **Bladder symptoms**
  - Stress leakage: cough/sneeze/intercourse
  - Urge leakage/urgency/frequency/nocturia
  - Hesitancy/slow voiding/incomplete emptying
  - Haematuria/bladder pain/recurrent UTIs
  - Overactive bladder symptoms
  - Voiding symptoms

- **Sexual function symptoms**
  - sense of obstruction or discomfort

- **Bowel symptoms**
  - Obstructed defecation symptoms

Incontinence – Definitions (ICS - International Continence Society 2018)

Stress urinary incontinence (SUI): Complaint of involuntary loss of urine on effort or physical exertion including sporting activities, or on sneezing or coughing.

Overactive bladder (OAB, Urgency) syndrome:
Urinary urgency, usually accompanied by increased daytime frequency and/or nocturia, with urinary incontinence in the absence of urinary tract infection or other detectable disease.

Urgency urinary incontinence (UUI):
Complaint of involuntary leakage of urine from urethral orifice associated with urgency
Urgency: Complaint of a sudden compelling desire to pass urine, which is difficult to defer
Increased urinary frequency:
Complaint that voiding occurs more frequently during waking hours than deemed normal by individual

Nocturia:
The number of times an individual passes urine during their main sleep period, from the time they have fallen asleep up to the intention to rise from that period. This is derived from the bladder diary.

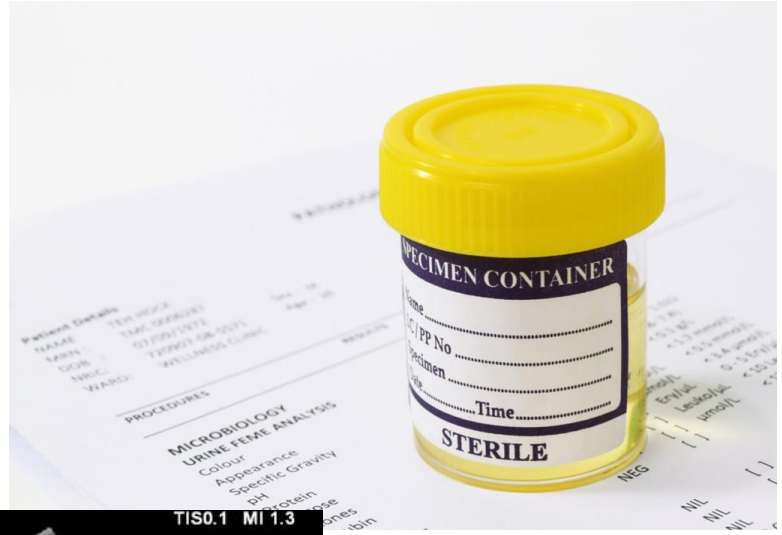
Mixed urinary incontinence (MUI):
Complaints of both stress and urgency urinary incontinence, i.e. involuntary loss of urine associated with urgency and also with effort or physical exertion including sporting activities or on sneezing or coughing.

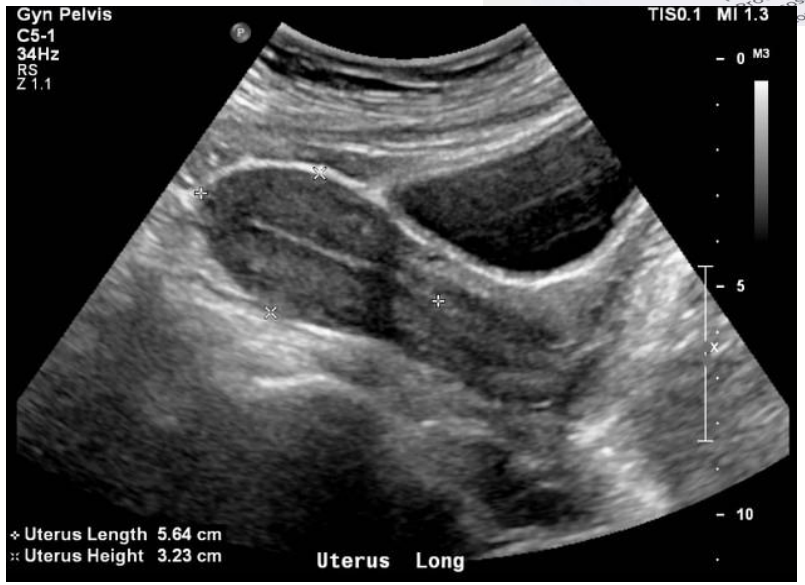
Risk Factors

- Age
- Pregnancy
- Vaginal birth
- BMI
- Medical conditions e.g. neurological, diabetes, etc
- Medications e.g. diuretics
- Adult Mixed Urinary Incontinence and Urge Urinary Incontinence – more likely to have had childhood enuresis
- Previous surgery for Stress Urinary Incontinence
- Urinary microbiome

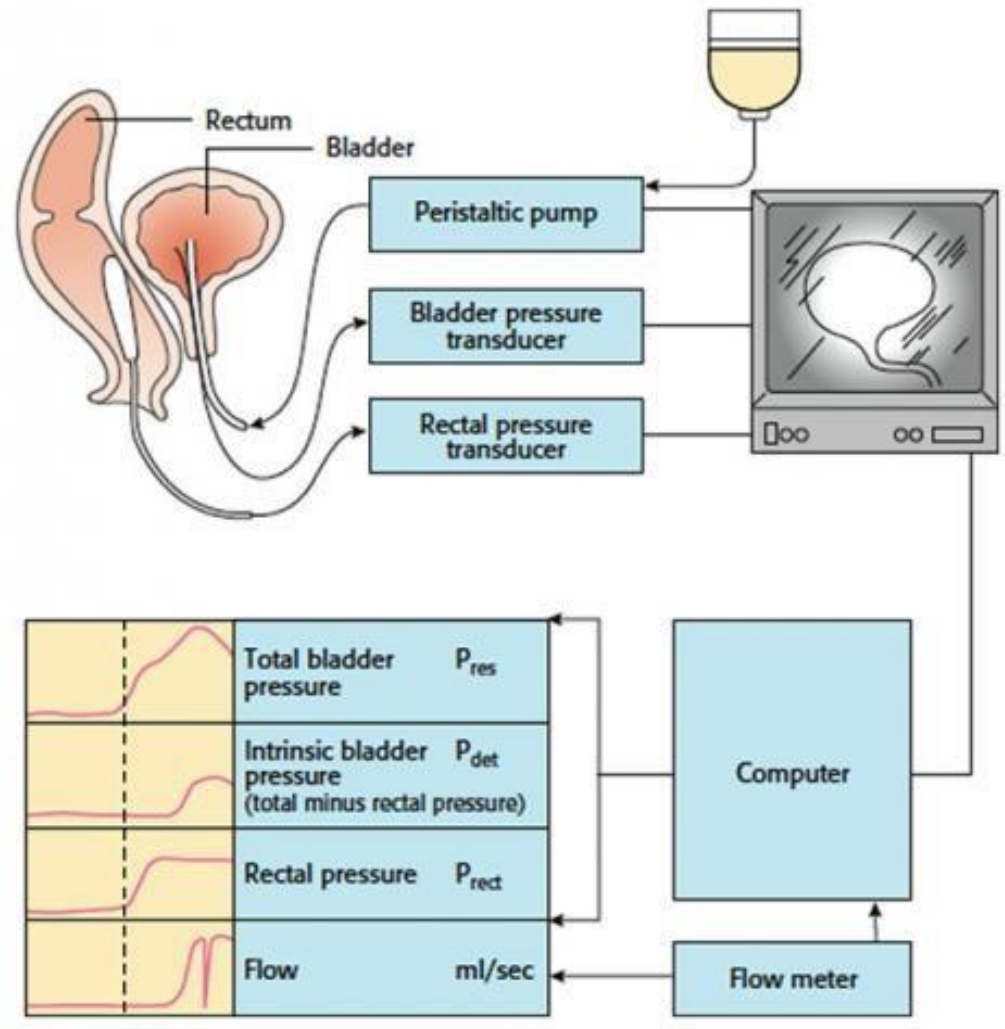
Investigations

- MSU for M/C/S
- CST if due
- ? Pelvic USS +/- renal tract US + post void residual volume; masses
- ? Bloods if obstruction suspected
- Bladder diary (3 days)
- Urodynamic studies





URODYNAMICS STUDIES



Management: Mixed UI

Varies:

“Traditionalists”
- Least invasive intervention

“Purists”
- Treat most bothersome urinary incontinence subtype
  - i.e., presenting complaint

“Interventionalists”
- Surgery

Management: SUI

- Do nothing if not bothersome
- Non-surgical
  - Lifestyle changes
  - Oestrogen cream
  - Continence pessary/device
  - Pelvic floor physiotherapy: Pelvic floor muscle training
- Surgery

Management: OAB

Conservative

- Lifestyle changes
- Bladder retraining/PFMT – pelvic floor physiotherapy
- Vaginal estrogen

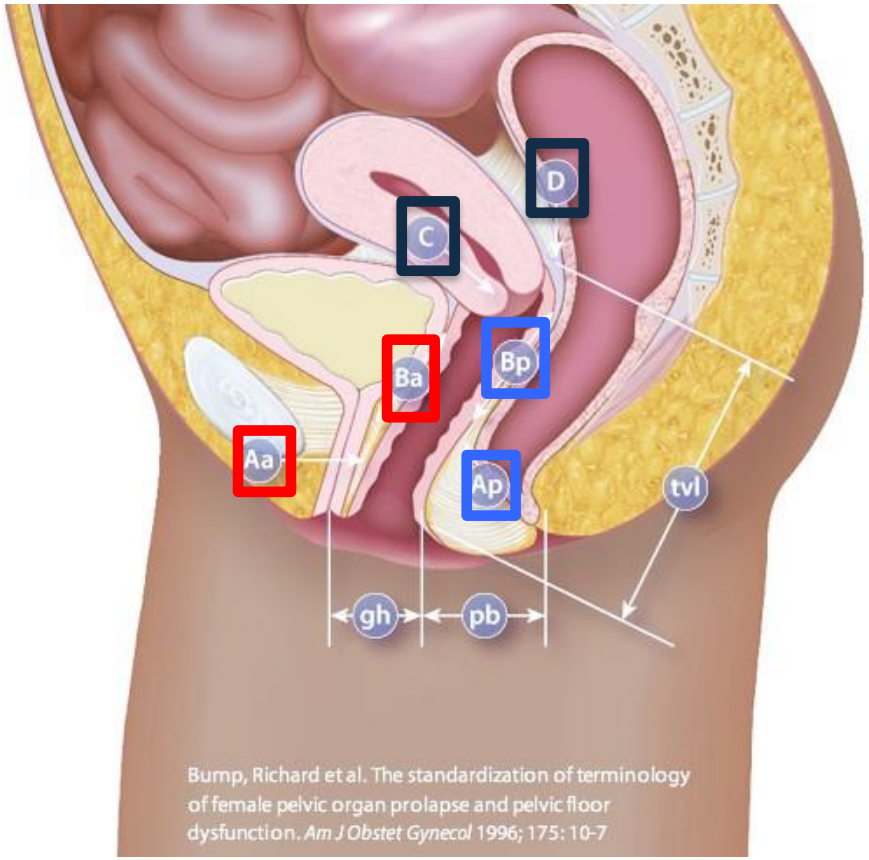
Medical

- Anticholinergics: Oxybutynin (oral/patch); Solifenacin – Vesicare (selective for M3 bladder receptors)
- Mirabegron – Betmiga (activates β3 adrenergic receptor)
- Intravesical Botox

Electrical stimulation

- Percutaneous tibial nerve stimulation (PTNS)
- Sacral nerve stimulation (SNS)

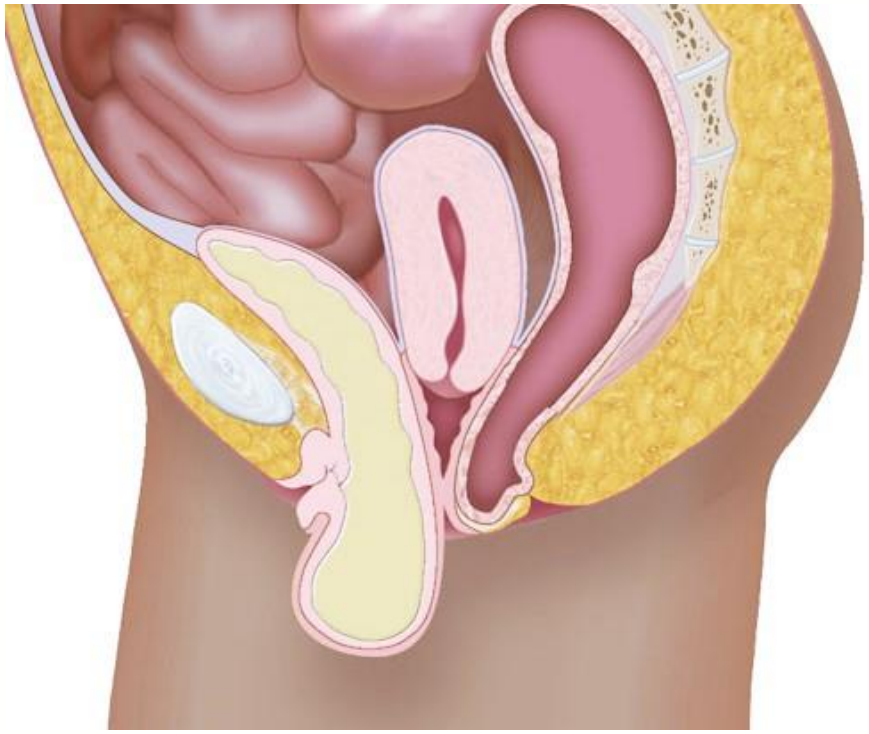
Urogynaecology Exam : POPQ



Bump, Richard et al. The standardization of terminology of female pelvic organ prolapse and pelvic floor dysfunction. *Am J Obstet Gynecol* 1996; 175: 10-7

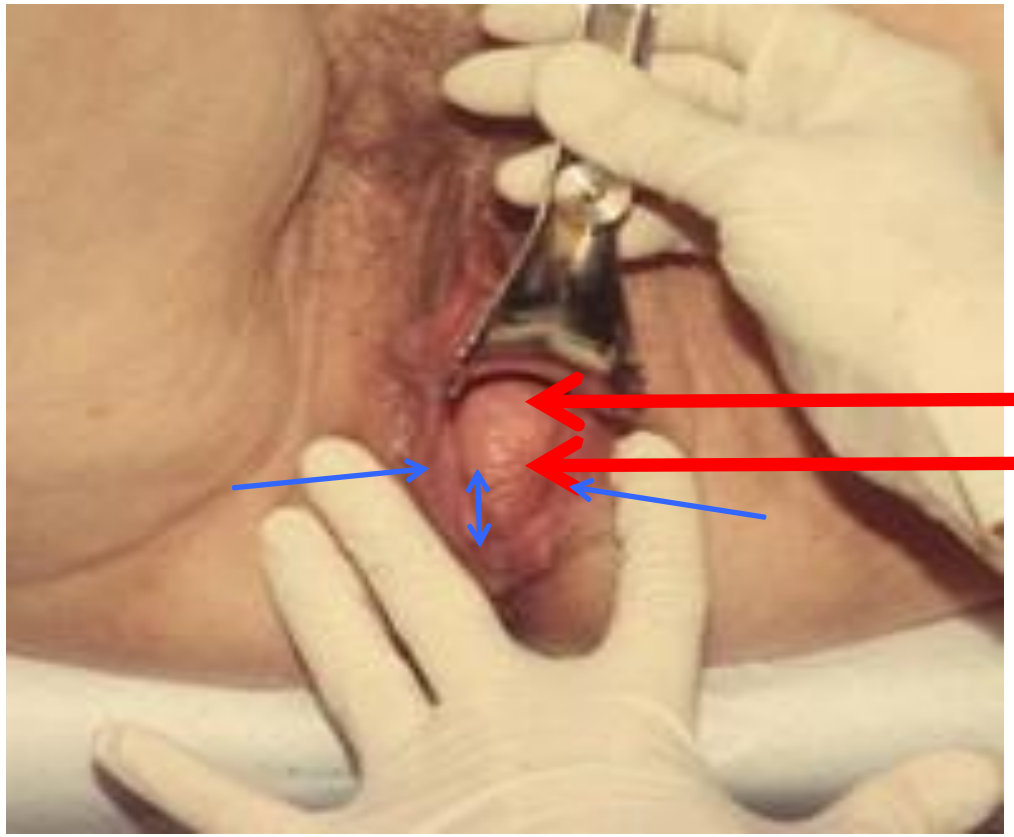
anterior wall **Aa**	anterior wall **Ba**	cervix or cuff **C**
genital hiatus **gh**	perineal body **pb**	total vaginal length **tvl**
posterior wall **Ap**	posterior wall **Bp**	posterior fornix **D**

EXAMINATION: ANTERIOR WALL



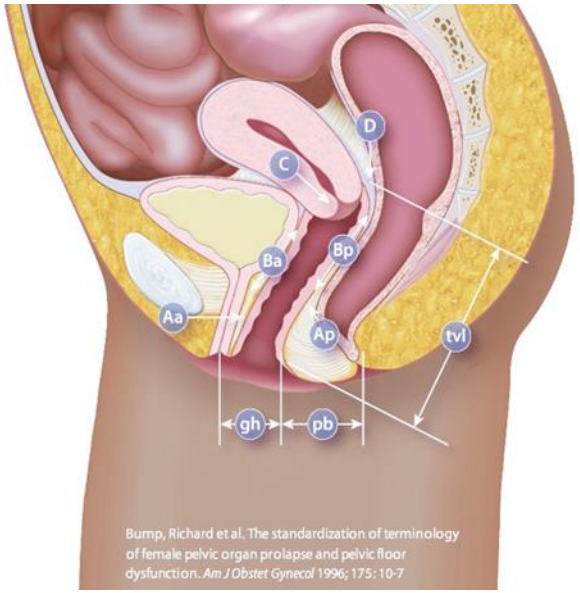
Aa **+ 2**	**Ba** **+ 3.5**	**C**
Gh	**Pb**	**TVL**
Ap	**Bp**	**D**

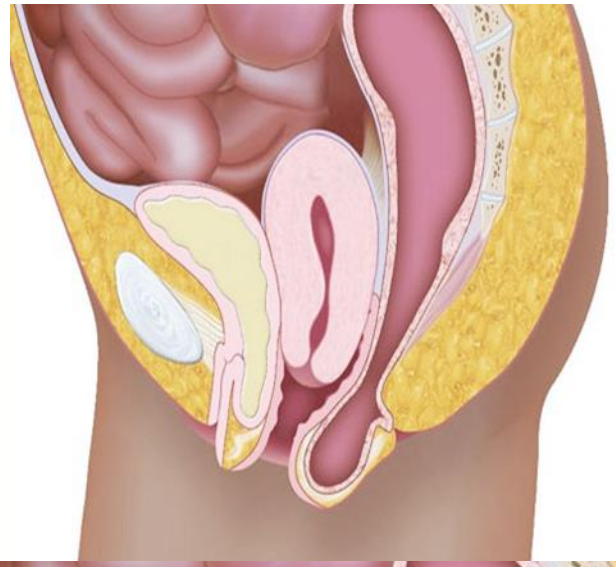
Urogynaecology exam: posterior wall

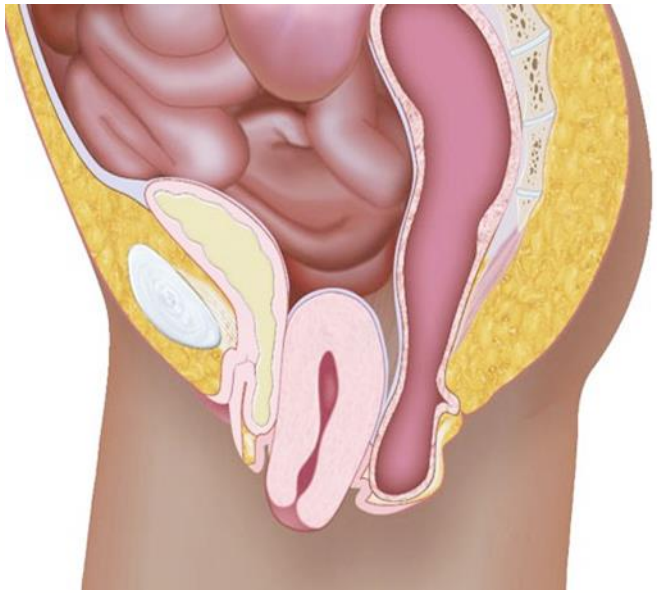


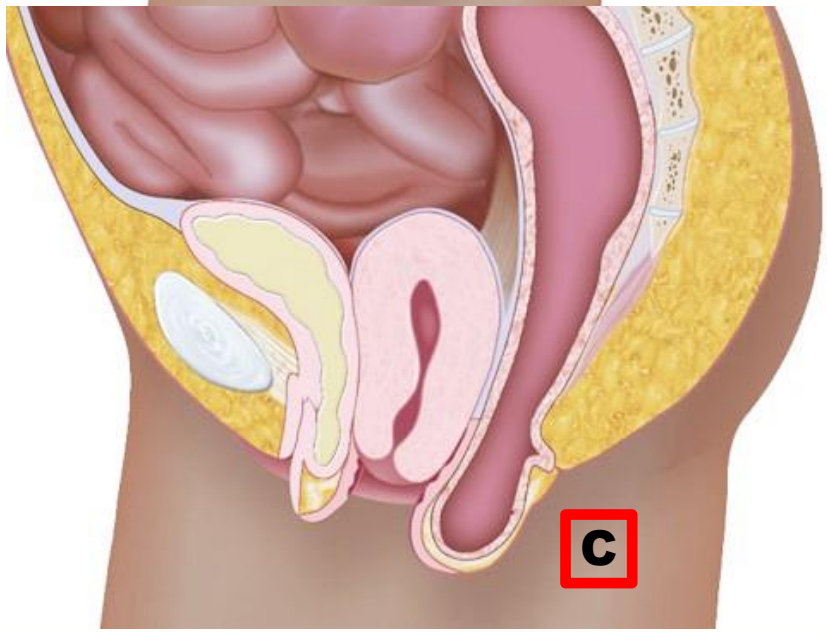
Bp
Ap
** 3cm from posterior fourchette

Urogynaecology exam: apical







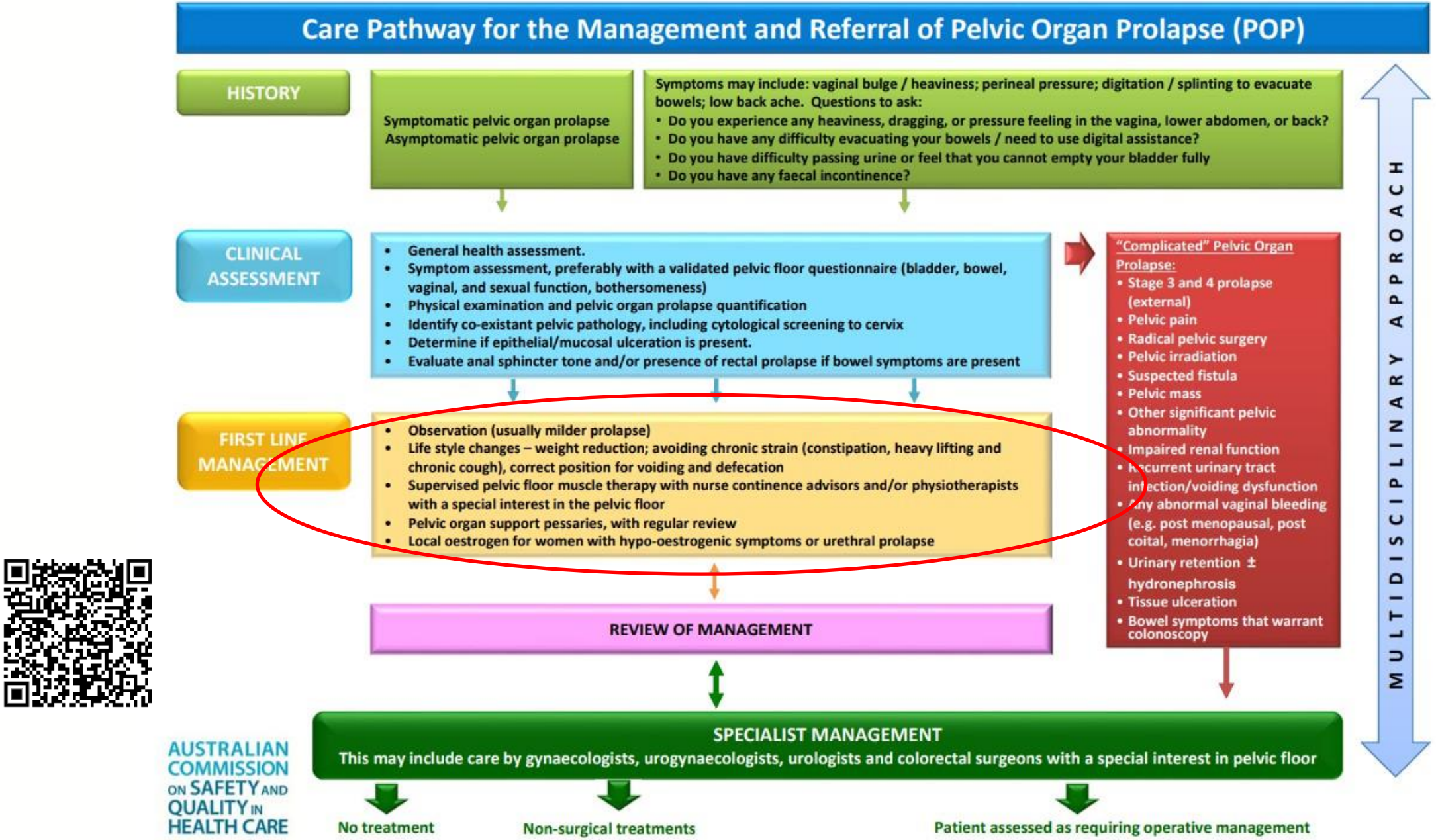


Investigations

- MSU for M/C/S
- Urine cytology if red flags
- US pelvis +/- TV
- US renal tract

- **Pelvic floor ultrasound NOT necessarily helpful**

CARE PATHWAY for the Management and Referral of Pelvic Organ Prolapse – Australian Health Commission



Use of Vaginal Oestrogen

Average level of serum estradiol

- Premenopausal women : 160 – 400 pg/ml
- Post-menopausal women: <35 pg/ml

Systemic absorption of intravaginal administration is low and unlikely to contribute to systemic side- effects

- Vagifem (Estradiol) 10mcg tablet = 3 – 11pg/ml
- Ovestin (Estriol) 1mg/gm, applicatorful ~ 0.5g = 0.5pg/ml
- Estradiol, daily use ~ average plasma level around 40pg/ml

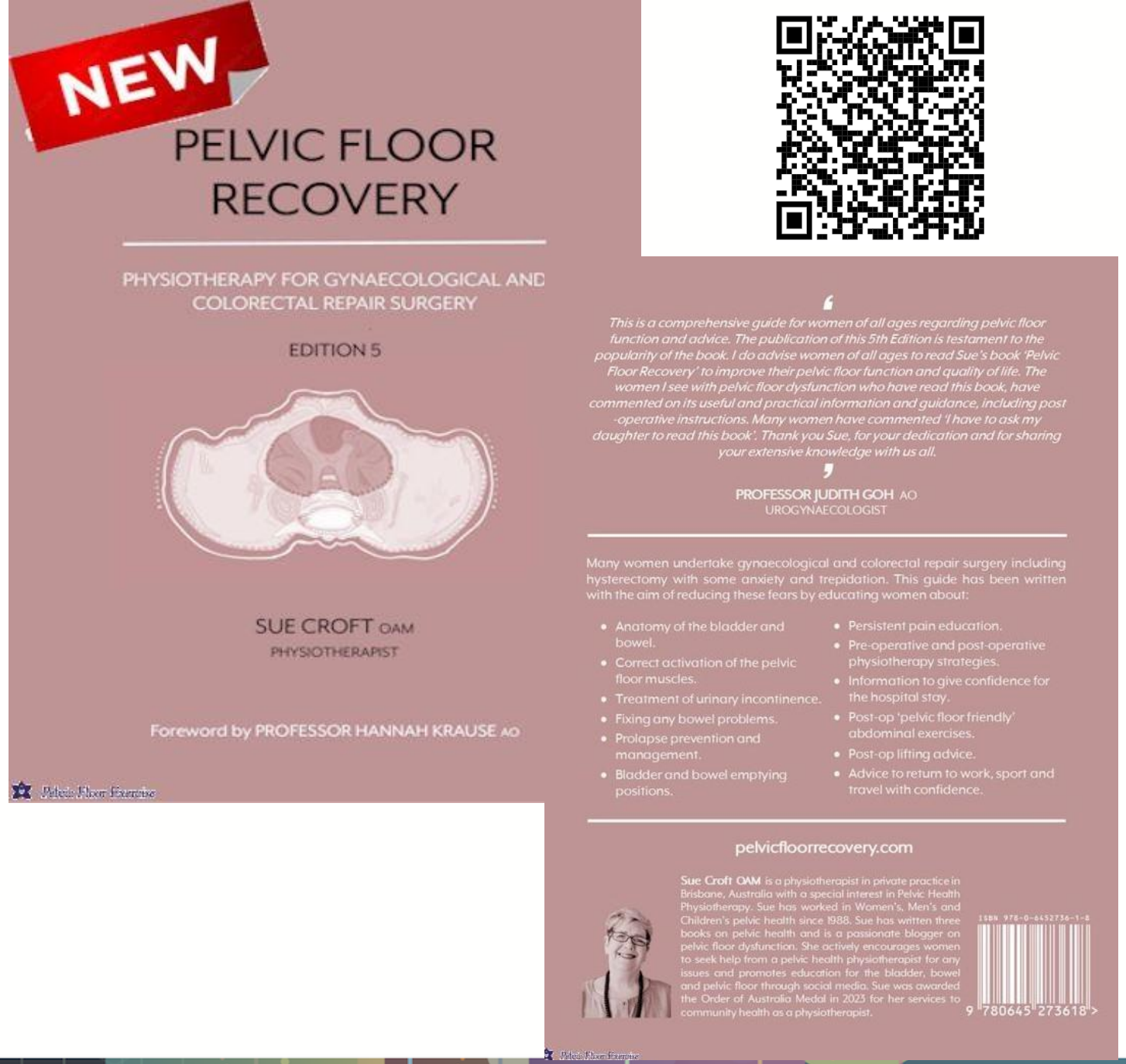
Use nightly for first 2 weeks then 2x/week thereafter

Evidence to support use

- Urinary Incontinence - *Cochrane 2022*
  - Local estrogen treatment; RR 0.74 – 1-2 fewer voids/24hrs, less frequency and urgency
- Prolapse - *Cochrane 2023*
  - Limited evidence for use of oestrogen in prevention/ management of POP symptoms
  - Likely fewer adverse vaginal events compared with pessaries alone & topical oestrogen in conjunction with surgery was associated with reduced postoperative UTIs
  - Lowest dose to achieve benefit, review annually

RED FLAGS

REFER TO GYNAE/UROGYN



Pelvic Floor Essentials (Edition 4) is for girls and women who haven't had a baby; who are thinking of getting pregnant; who are pregnant; post-partum (had their baby) or are peri-menopausal or post menopausal.

Pelvic Floor Recovery: Physiotherapy for Gynaecological and Colorectal Repair Surgery (Edition 5) is definitely for those women contemplating surgery or who are undergoing surgery or who have had surgery (repair operations or a hysterectomy). It is also for women who are post-menopausal and may not have had surgery or need it, but do not need all the pregnancy and childbirth information in Essentials. If you buy this one just skip the surgery pages.

Pelvic floor dysfunction - prolapse or incontinence (Gynaecology) - REFER YOUR PATIENT (Metro South)

- **Medical management**
- Lifestyle modification (Increased activity, dietary, weight, smoking, alcohol)
- Treat constipation
- Consider referral to women's health physiotherapist for the following:
  - Prolapse –pelvic floor exercise program, consider pessary
  - Stress incontinence – pelvic floor exercises, bowel management and consideration of supportive devices(e.g Contiform) and bladder retraining for 3 months prior to referral
  - Overactive bladder symptoms-bladder training; consider for tibial nerve stimulation; exclude infection
- Consider trial of anticholinergics or Mirabegron (Betmiga)
- Consider topical oestrogen in post-menopausal women

- Patients with **chronic pelvic pain following mesh procedures** can be referred to the Queensland Pelvic Mesh Service (QPMS) for assessment - offers comprehensive, interdisciplinary assessment and treatment for women with complications from pelvic mesh.
- Further information is available on:
  Qld Health website
  Queensland Pelvic Mesh Service (QPMS) website – located at Varsity Lakes Day Hospital
  QPMS Referral Form
  Patient resources

Metro South Health

Quality healthcare every day

Physiotherapy Services
Women's, Men's and Pelvic Health Physiotherapy
Metro South

Melanie Walkenhorst
Advanced Physiotherapist- Clinical Lead
Logan and Beaudesert Hospitals
Ph: 07 3299 8858

ICARE² values

INTEGRITY COMPASSION ACCOUNTABILITY RESPECT ENGAGEMENT EXCELLENCE

Queensland Government

Logan Hospital Service

Inpatient

- Maternity Inpatient Unit
- Post Surgical (OPD referral)

Outpatient

- Antenatal/Postnatal Classes
- Antenatal/Postnatal individual appointments
- Pelvic Floor dysfunction (Adult Female & Male service)
- Post Gynaecological, Urology & Colorectal surgery

Beaudesert Hospital

Inpatient

- Maternity Inpatient Unit

Outpatient

- Antenatal/Postnatal individual appointments

Satellite clinic from Logan Hospital:

- Pelvic Floor dysfunction (Adult Female & Male service)
- Post Gynaecological, Urology & Colorectal surgery
- OASI

QE11 Hospital Service

Outpatient Service only

- Pelvic floor dysfunction (male and female adults)
- Pre-operative and post-operative Urogynaecology, Gynaecology, Colorectal and/or Urology
- Breast cancer: pre-operative and post-operative management (including referring to Occupational Therapy team for surveillance / treatment for high-risk patients)

Redland Hospital Service

Inpatient

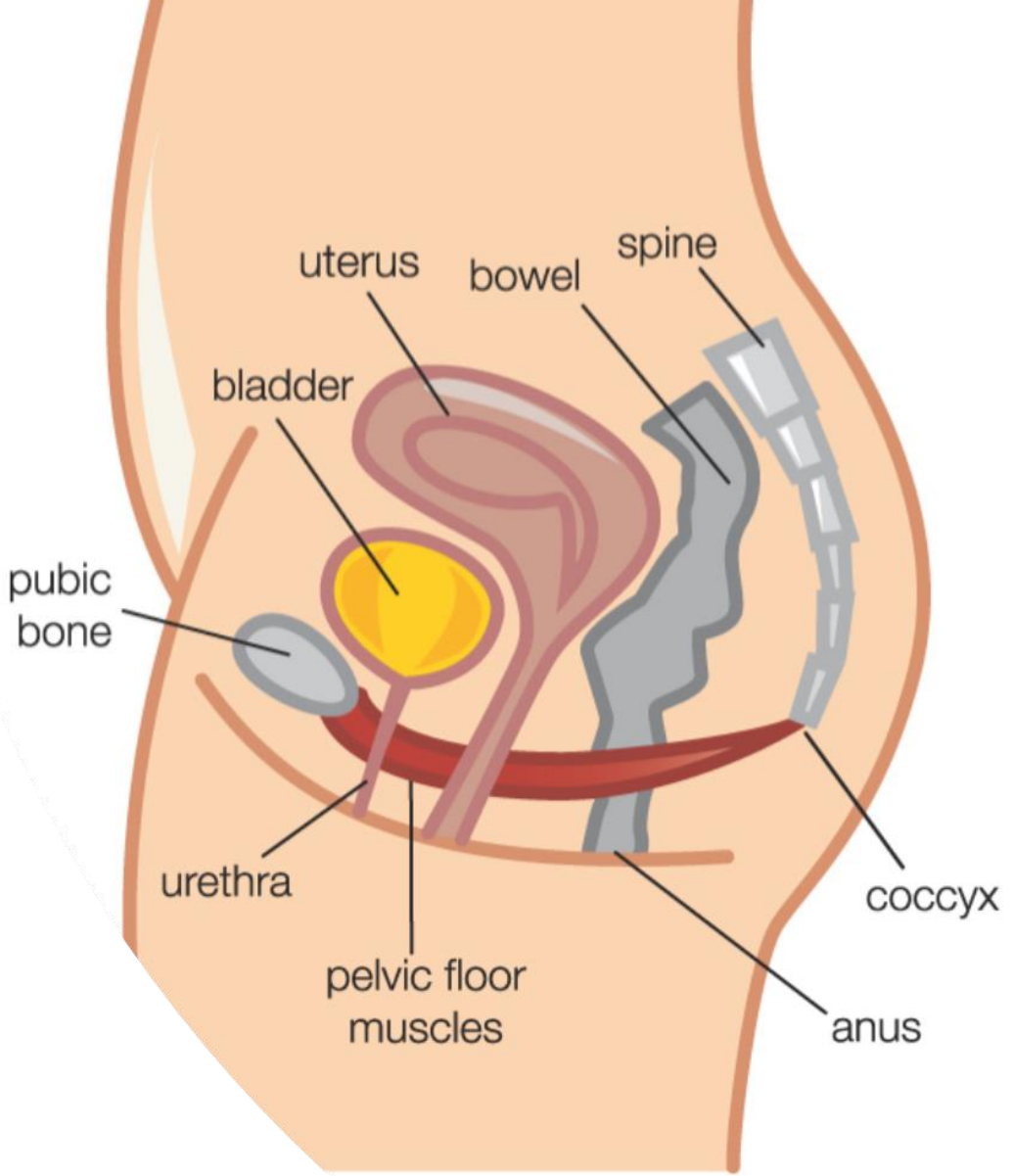
- Maternity Inpatient Unit (2hrs each weekday)

Outpatient

- Antenatal / Postnatal classes
- Antenatal /Postnatal individual appointments
- Pelvic floor dysfunction

Pelvic Floor Dysfunction

- Bladder and bowel dysfunction including incontinence, constipation and muscle dysfunction
- Pelvic organ prolapse
- Pelvic pain syndromes
- Postnatal conditions incl. obstetric anal sphincter injury
- During pregnancy



dation of Australia 2013

Women's, Men's and Pelvic Health Physiotherapy Referrals

GP referrals are received:

1. Directly from the GP to the Physiotherapist through a SMART Referral or e-referral to the Central Referral Hub
2. Primary referral - Triaged by a Specialist Medical Officer through to our Pelvic Health Clinic

Pelvic Health Clinic

The Pelvic Health Clinic allows your patient the benefit of seeing a Physiotherapist whilst waiting for a Specialist appointment:

- Reduced waiting time to access care
- Learn strategies for self-management
- Improved clinical outcomes due to earlier commencement of conservative treatment

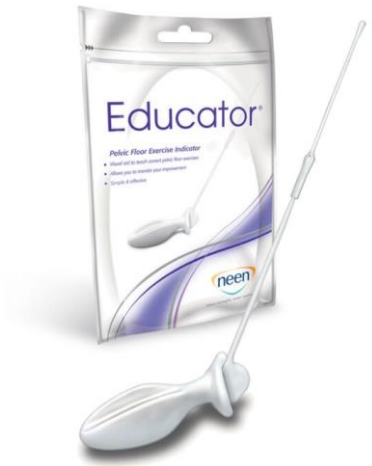
The clinic works in collaboration with several medical specialties including:

- Gynaecology
- Urogynaecology
- Colorectal
- Urology

Patients are seen by an Advanced Physiotherapist in Women's, Men's and Pelvic Health at the recommendation of a Specialist Medical Officer.

Physiotherapy Management Overview

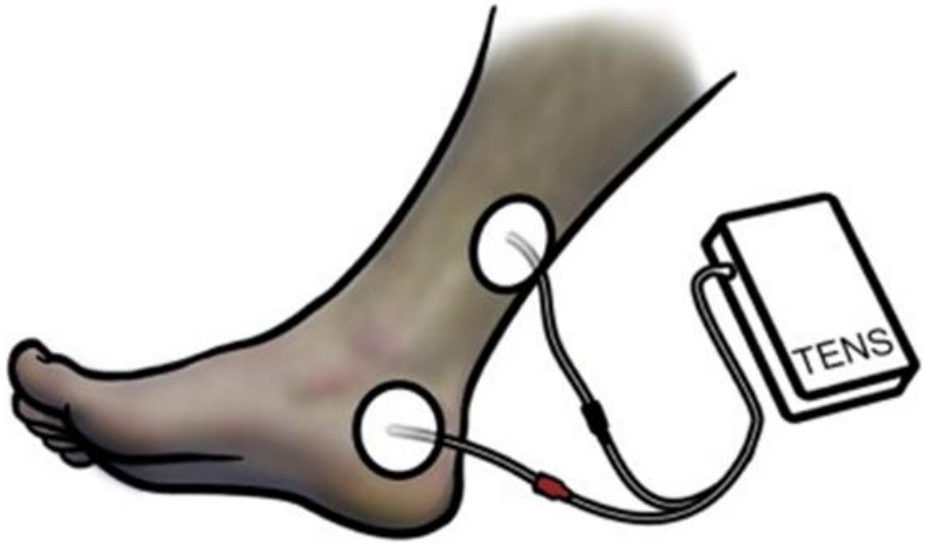
- Education
- Exercise
- Pelvic floor training
  - Strengthening
  - Coordination
  - Endurance
  - Electrical Stimulation
  - Downtraining
  - Biofeedback



Physiotherapy Management- Urinary dysfunction

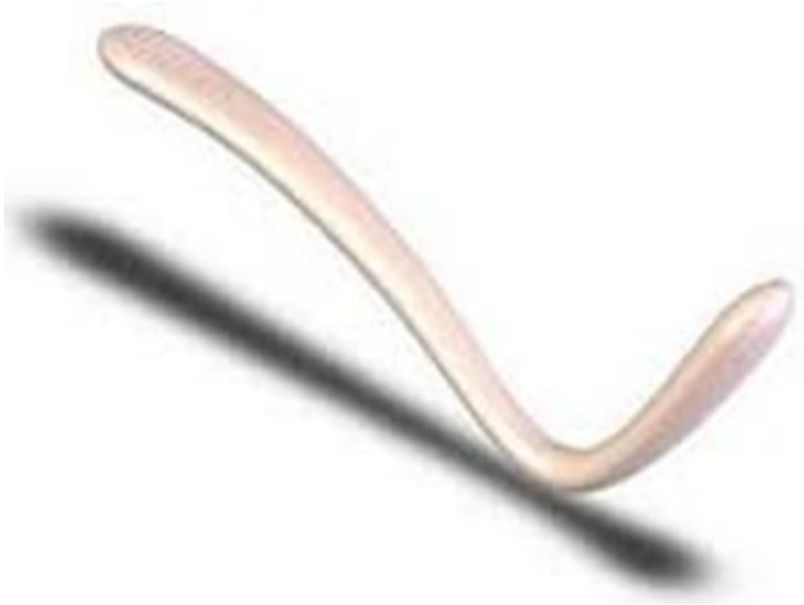
i.e. Urinary Incontinence, Voiding dysfunction, Bladder urgency

- Pelvic Floor rehabilitation
- Bladder management
  - Bladder retraining
  - Bladder diary assessments
  - Voiding strategies
  - Neuromodulation
    - Vaginal
    - Sacral
    - Tibial Nerve



Physiotherapy Management – Bowel dysfunction

- i.e. Faecal Incontinence, defecation dynamics, Faecal Urgency



- Bowel Management
  - Defecation position and dynamics
  - Bowel Routine
  - Stool type modification
  - Bowel diary assessments
  - Biofeedback
  - Neuromodulation

Physiotherapy Management – Persistent Pelvic Pain

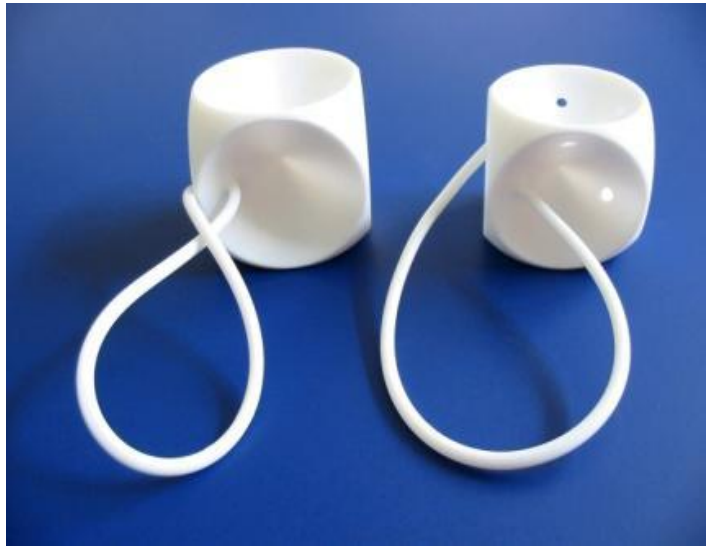
- Pain management
  - Pain neuroscience education
  - Downtraining
  - Biofeedback
  - Desensitisation
  - Soft tissue release
  - Neuromodulation

Physiotherapy Management - Prolapse

- Lifestyle Education
- Defaecation dynamics / Constipation management
- Pelvic floor rehabilitation
- Pessary management –self management

Physiotherapy Management - Pessaries

- Patient self-management required
- 2A TGA Classification
- Flexible Silicone device



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Physiotherapy Management - Pessaries

Contraindication checked:

- active infections
- pelvic inflammatory disease
- undiagnosed bleeding
- The patient agreeable to have follow up as instructed with therapist and with GP at 6 months and 12 months speculum check for the life of the pessary use.

Precautions considered:

- Bimanual assessment by GP or Gynae
- Patient requiring topical vaginal oestrogen for vaginal health
- Hx of Mesh
- Mirena/IUD

Physiotherapy Management - Pessaries

Patient are instructed on:

- cleaning
- insertion
- removal
- replacement
- when to discontinue use: discomfort / pain, feeling unwell, vaginal bleeding, offensive discharge or difficulty urinating/ defecating

Queensland Government

METRO SOUTH HEALTH SERVICE DISTRICT
LOGAN HOSPITAL
Women's, Men's and Pelvic Health Physiotherapy Service
Allied Health Department
Telephone: 07 3089 6734

RE:
DOB:
Logan Hospital UR:
Treating Physiotherapist:

I

of :

Understand that in order to support the Physiotherapist in providing care involving the use of a pessary to the above mentioned patient, I understand that this will require a:

- 6 monthly review of progress with pessary use
- Plus an annual speculum examination
- A prescription letter to manufacturer for subsequent pessary replacement – to be provided to patient (as required)
- With any adverse event to be noted to the treating physiotherapist

PLEASE TICK YOUR RESPONSE BELOW

I am willing and able to provide the medical support required to assist the above mentioned patient to trial a pessary to assist with her pelvic floor condition.	☐

OR

I am **NOT** willing and able to provide the medical support required to assist the above mentioned patient to trial a pessary to assist with her pelvic floor condition.	☐

Signature:

Date:

If you are happy to provide this support would you kindly return the last page of this letter via email **Pelvic_Health_Clinic@health.qld.gov.au** or fax **3299 8280**.

Medical Store
Medicalstore Pty Ltd
4/264 Wickham Road, Highett, VIC 3189
T 03 9553 2700
F 03 9553 4858
www.medicalstore.com.au

Enquiries to:

Telephone:

Date:

To whom it may concern,

RE: PATIENT NAME
DOB: XX/XX/XX

PATIENT NAME has been fitted with a **SIZE & STYLE, REF:** style pessary for ongoing management of her condition.

It would be greatly appreciated if you could please supply a replacement pessary for this patients ongoing use.

(Ctrl)

Kind Regards

Clinician Name
TITLE
CLINIC NAME

Questions

Session 2

Time	Session name	Presenter	Delivery
10:30 am	Case Discussions – Pelvic Floor Prolapse and Urinary Incontinence	Group Spokesperson Dr Hasthika Ellepola	Facilitated groups Power Point Presentation & Forum Discussion
10:50 am	Physiotherapy Management of Prolapse, Urinary and Faecal incontinence; Physiotherapy Pelvic Health Service in MSHHS	Melanie Walkenhorst	Power Point Presentation & Forum Discussion
11:15 – 12:30pm	Hands-On Practical Demonstrations - Vaginal Pessaries - Implanon Insertion - IUD Insertion Simulator - Pipelle Biopsy Demo - Novasure/Myosure Demo	Breakout Group Rotations	Facilitated groups Power Point Presentation & Forum Discussion
12:30 pm	Wrap Up CPD Discussion	Dr Kim Nolan ALL	ALL

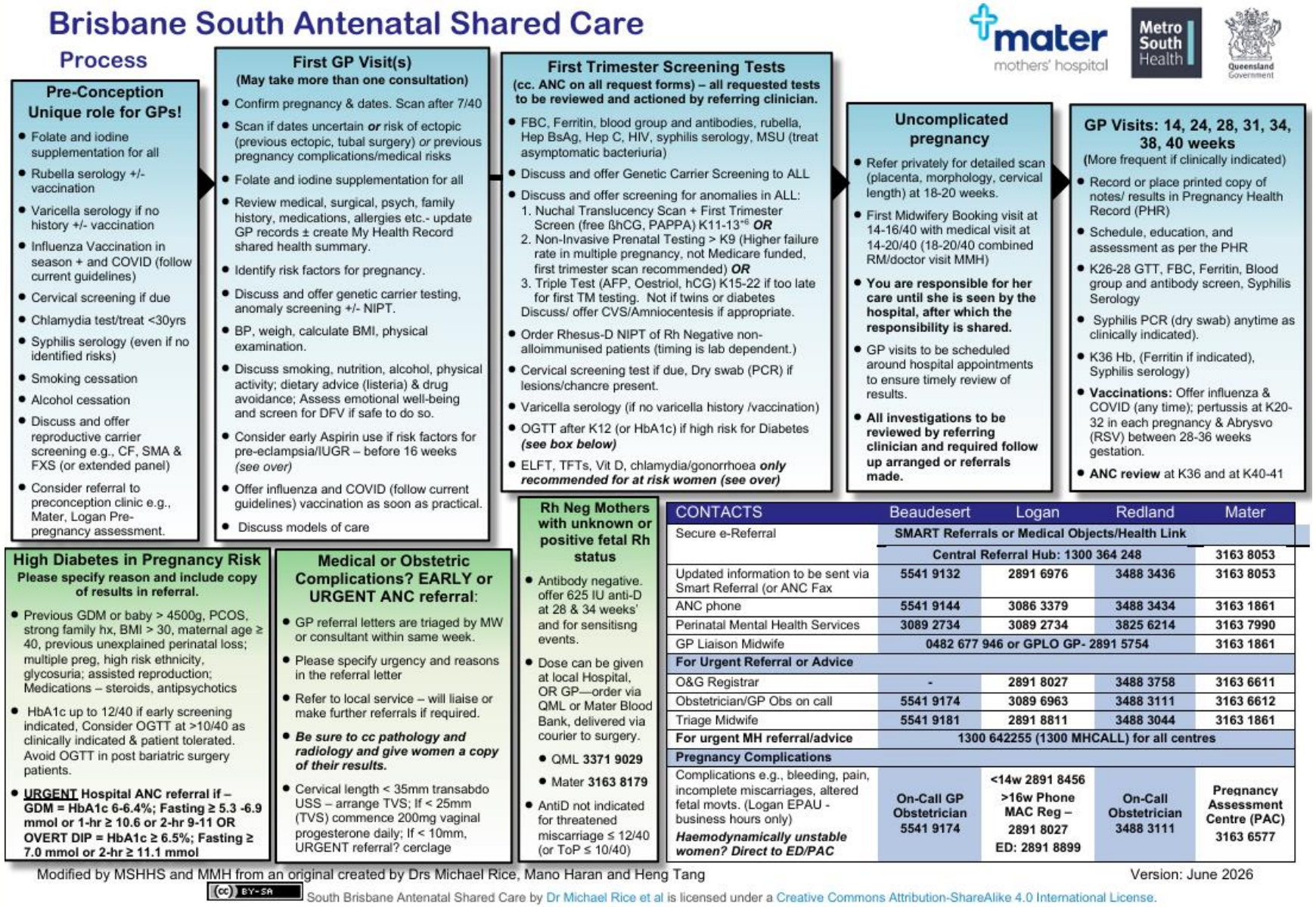
Breakout Groups

- IUD Simulator Insertions
- Speculum insertion Demonstration
- Pipelle Biopsy Demonstration
- Implanon Insertions – Models
- Pessaries and Pelvic Floor Musculature Demonstration
- Novasure/Myosure Demonstration

Thank you for your attendance today!

Undertake Evaluation/Feedback – link below – please let us know what we did well and what we could do better!

Brisbane South Antenatal Shared Care Summary – June 2026



Available at

https://metrosouth.health.qld.gov.au/referrals/general-practice-liaison-officer-gplo-program

https://www.metrosouth.health.qld.gov.au/__data/assets/pdf_file/0023/291704/bsphn-whole-of-region-summary.pdf

Maternity GP Shared Care
Additional Information and Advice

Additional Tests – STI screen, ELFT, TSH/TFTs, Vit D, TORCH serology

- Chlamydia and Gonorrhoea --test women < 30 years old and other high-risk women by self-collect PCR swab.
- ELFTs and urinary protein/creatinine ratio recommended for obese women (BMI > 30), hypertension or known or suspected renal or liver disease, autoimmune disease.
- Routine TFTs *are not* recommended in low-risk pregnant women. TSH generally drops in first trimester with the rise in HCG. If a woman has a TSH lower than the lab reference range, check free T4/T3—if these are normal, the woman *does not* need referral, if elevated, they will need clinical review, possibly referral – liaise with your local team. https://metronorth.health.qld.gov.au/wp-content/uploads/2017/10/thyroid-disorders-pregnancy.pdf
- Women with pre-existing hypothyroidism should have a TSH <2.5 in first trimester and <3.0 in the rest of the pregnancy. Lab reference ranges will reflect pregnancy recommendations if the woman is identified as being pregnant. Weekly doses usually need to increase by 30% during pregnancy, which is an extra 2 doses/week. Advise women to commence the higher dose as soon as they know they are pregnant.
- Vitamin D levels or supplementation are recommended for obese *or* dark-skinned women *or* those with little sun exposure *or* who cover themselves for religious or cultural reasons. Levels <50 may require supplements of 2000 IU/day. Levels <15 require higher doses and re-test after 3 months.
- Toxoplasma, cytomegalovirus, and herpes serology should *not* be performed routinely. If risk factors indicate a need for testing, please include risk in your referral as follow-up tests or other investigations or management may be needed.

Nutrition and Supplements

- Folate - 0.5 mg for all low risk, 2.5-5 mg if high risk (diabetic, obese, previous, or familial neural tube defect, anticonvulsants). Start one month before conception & continue to 12 weeks.
- Iodine 150mcg/day - recommended preconception, during pregnancy and while breastfeeding (folate + iodine supplement is available)
- 2-3 serves daily of calcium-rich food/drink (1g/day) OR add 500mg minimum daily supplement. RANZCOG recommend universal 400IU/day Vitamin D (e.g., 600mg Ca + 1000IU Vit D)
- Iron only needed if deficiency is identified however low dose is included in all pregnancy supplements. Avoid Vit A in pregnancy.
- Added supplements needed for women post Bariatric Surgery (including Vitamin A) – seek Dietitian input.
- Avoid or limit intake of large/predatory fish due to mercury content (Orange Roughy /Sea Perch, Shark/Flake, Swordfish, Marlin etc.)

Early Low Dose Aspirin (100-150mg)

Commence before 16/40 (stop at 36/40) to reduce incidence of placental disorders such as Pre-eclampsia & fetal growth restriction (FGR), preterm birth & perinatal mortality in those at increased risk. Take in the evening.

High Risk Factors - recommend if patient has one or more of:
- Hypertension
- Renal disease
- Auto-immune diseases e.g., SLE or anti-phospholipid syndrome
- Diabetes (Type 1 or Type 2)
- Previous History of pre-eclampsia

Moderate Risk Factors – consider if two or more are present:
- Primiparous
- BMI > 35
- Age > 40
- Multiple pregnancy
- Family history of pre-eclampsia (mother or sister)
- More than 10 years since last pregnancy

Preventing Infections

- Toxoplasmosis - Avoid feeding raw/undercooked meats to pets, avoid cat faeces/litter, wear gloves when gardening.
- Cytomegalovirus - Good hand hygiene; Care with urine, saliva, nappies of young children
- Influenza and COVID Vaccination at any stage antenatally; pertussis vaccinations 20-32 weeks & RSV 28-36 weeks (but up to time of delivery if missed; requires two weeks to be fully effective)
- Listeriosis - Avoid soft cheeses, un-pasteurised milk, pate, raw eggs, hot dogs, undercooked and deli meats, reheated leftovers, precut fruit, bean sprouts.

More Online Information and Education for GPs interested in Antenatal Care are available through:

- General Practice Liaison Officer (GPLO) Program webpage: https://metrosouth.health.qld.gov.au/referrals/general-practice-liaison-officer-gplo-program
- Mater Mothers www.materonline.org.au (Click on Shared Care Alignment for a range of resources for GPs) www.matermothers.org.au (Click on Mater Mothers' Hospital for resources for women)
- www.maternity-matters.com.au has consumer and clinician resources and links to reputable websites.

Early Pregnancy Complications (<20 weeks)

- Nausea and vomiting - decrease iron (but continue iodine and folate), try ginger, acupressure, pyridoxine 75 mg/day in divided doses, doxylamine (Cat A) Metoclopramide (Maxolon Cat A) and Phenothiazines like Prochlorperazine (Stemetil Cat C, po/pr/iv, safe in first trimester); Ondansetron may be effective but is relatively expensive. Even mild dehydration/ketonuria may benefit from IV fluids.
- Bleeding: check blood group and antibodies. Threatened miscarriage in rhesus-negative women without antibodies (and unknown fetal Rh status) after 12 weeks requires anti-D, before 12 weeks anti-D is not required unless the miscarriage completes, or you are concerned the woman may not re-present.
- Bleeding and pain: consider ectopic pregnancy!
- Consider advice from, or referral to, early pregnancy assessment unit (EPAU), pregnancy assessment centre (PAC) or emergency department at booking hospital (appointments may be required)

Beaudesert 5541 9111; Logan EPAU (< K14) 3299 8456 – 8-4 Mon-Fri only
Redlands 3488 3111; Mater PAC 3163 6577

Late pregnancy complications (>16/40 at Logan; >20/40 at other Brisbane South maternity hospitals)

- Bleeding – can do spec exam but avoid PVE. Exclude cervical dilation. Re-check placental site on original morphology scan, Rhesus neg mothers (with unknown fetal Rh Status) need anti-D.
- Abdominal pain - can do spec exam but no PVE. Exclude cervical dilation.
- Ruptured membranes - Review at hospital preferred. Can do spec exam but no PVE.
- Fundal height > 3cm above or below expected for gestational age – arrange USS & if IUGR confirmed, refer to ANC by Fax *and* Phone Obstetrician/Registrar; if LGA confirmed, refer back through ANC
- Perceived change in fetal movements beyond 28 weeks or no FH detected – arrange IMMEDIATE hospital review.
- Most should be referred to booking hospital birth suites, pregnancy/maternity assessment/observation units or Emerg. Dept.

Beaudesert 5541 9111; Logan MAC
Redlands 3488 3111; Mater PAC 3163 6577

For feedback on this document, please email MSHHS GPLO Maternity Team at GPLO_Maternity_Share_Care@health.qld.gov.au

Modified by MSHHS and MMH from an original created by Drs Michael Rice, Mano Haran and Heng Tang. Edited & updated by Drs Kim Nolan, Margaret Robin and Michael Rice – June 2026
www.materonline.org.au | www.https://metrosouth.health.qld.gov.au/referrals/general-practice-liaison-officer-gplo-program

General Practice Liaison Officer (GPLO) Program

Our GP liaison officers help GPs refer patients to our hospitals. We also train GPs who want to work with our maternity services in shared care.

On this page

How we help GPs

We have 2 teams to support GPs, our GP liaison officers (GPLO) and our GPLO Maternity Shared Care Team.

Our GP liaison officers can help you:

- understand our services
- refer patients to our hospitals and health centres
- use Brisbane South HealthPathways
- update your practice details in the Secure Transfer Service (STS) address book
- use the Health Provider Portal to access your patients' health records.

Contact a liaison officer

You can talk to our liaison officers in person, over the phone or by email.

- Email: GPLO_Programs2@health.qld.gov.au
- Phone: 1300 364 155 select option 2 – Monday to Friday between 8 am and 4 pm.

Maternity services support

Our GPLO Maternity Shared Care Team is based at Logan Hospital. We work with maternity services teams in our hospitals and GPs who practise in the Metro South Health area.

We help with:

- referrals
- patient handovers
- liaise with the obstetric team on your behalf.

We also run GP alignment education events each year. Search our events for future sessions.

Contact the GPLO Maternity Shared Care Team

Dr Kim Nolan
M.B.B.S; DRANZCOG; FRACGP; DCH
GPLO General Practitioner – Maternity
Obstetrics and Gynaecology Department
Logan Hospital
Phone: 07 2891 5754
Email: GPLO_Maternity_Share_Care@health.qld.gov.au

Lisa Miller
General Practice Liaison Midwife Manager
Women's & Children's Services | Logan Bayside Health Network
Logan Hospital
Phone: 0482 677 946
Email: GPLO_Maternity_Share_Care@health.qld.gov.au

GPs wishing to provide shared antenatal care at MSH region hospitals are encouraged to become aligned. There are a number of options to alignment including completion of a DRANZCOG, Certificate of Women's Health, MMH or MSH Alignment 1 seminar. See flowchart outlining the Alignment/Re-Alignment Options and further resources on the GP Maternity Share Care Education event page.

General Practice Liaison Officer (GPLO) Program Metro South Health

https://metrosouth.health.qld.gov.au/referrals/general-practice-liaison-officer-gplo-program

Great news for MSHHS Aligned GPs!

- After extensive negotiations on your behalf, MSHHS now hosts a public facing list of Aligned GPs, in keeping with MMH and Gold Coast University Hospital.
- Please email GPLO_Maternity_Share_Care@health.qld.gov.au if you do NOT want your name and suburb published.
- Please encourage any of your colleagues who have allowed their MSHHS Alignment to lapse, or have never completed Alignment to do so, with this free publicity in mind!
- Great way to build a practice, baby by baby!!

Maternity
Logan Hospital

Care and services for women, babies, and families throughout pregnancy, during labour, birth, and after birth.

On this page

If you're in labour, please call us on 07 3299 8663 before you go to hospital so our midwives are ready for you.

If you're less than 20 weeks pregnant and need medical care, please get in touch with your GP or go to your closest emergency department.

Our services

Having a baby is an exciting and life changing journey. We can help you choose the pregnancy care that's right for you. This may depend on any medical or pregnancy health concerns you have.

As well as Logan Hospital, Metro South Health has birthing hospitals at Redland and Beaudesert. All of our hospitals will give you and your family the best level of care as you start your journey into parenthood.

Please see your GP or a private midwife for your first appointment. Once you decide who will be caring for you and your baby during your pregnancy and birth, they'll let us know.

Pregnancy care

Service Locations | Metro South Health

https://www.metrosouth.health.qld.gov.au/services/maternity/maternity-logan-hospital#section__pregnancy-care

Your options for care during pregnancy include:

- **GP shared care**—your GP works with the hospital to take care of you.
- **Hospital midwifery care**—midwives at the hospital look after you.
- **Private midwifery care**—you can choose your own midwife to take care of you.
- **Specialist obstetric care**—you'll get care from doctors who specialise in pregnancy and childbirth.
- **Midwifery Group Practice (MGP)**—a team of midwives will look after you.

More information on your maternity care options is available on the Queensland Health website.

GP shared care

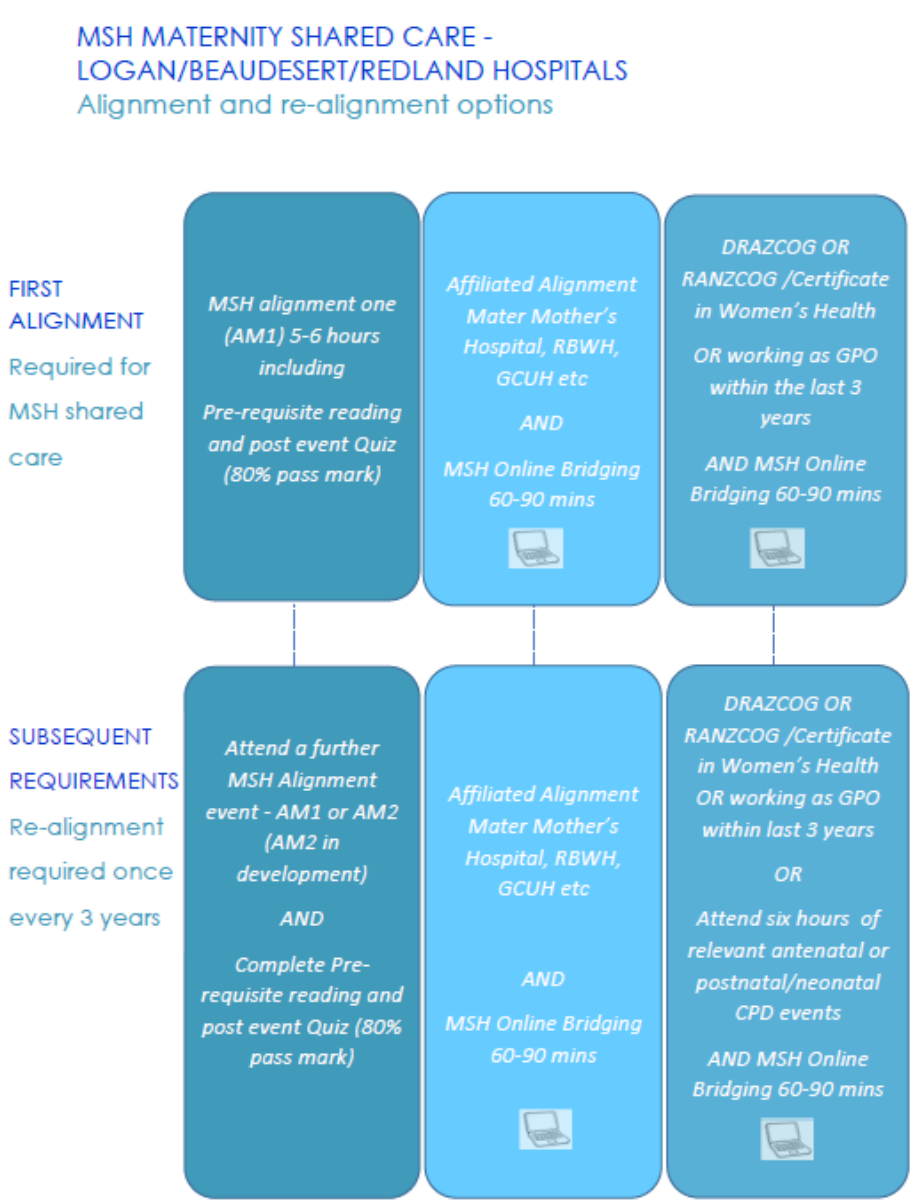
If you don't have any complications, you may choose to have most of your pregnancy care with your GP.

We'd still like to see you for the first booking appointment and again at 20, 36 and 41 weeks. If you develop any complications during pregnancy, your GP will refer you to us for ongoing care.

In GP shared care:

- most of your appointments will be with your GP
- you'll have 3 to 4 hospital appointments
- your baby will be born in hospital.

The Metro South GP Shared Care Alignment Program provides GP's with the latest information and health advice on obstetric and maternity care in shared care arrangements. See the full list of GP's who have completed the program.



GPLO Maternity GP and Midwife Manager
General Practice Liaison Officer (GPLO) Program | Metro South Health
Email: GPLO_Maternity_Share_Care@health.qld.gov.au Phone: 07 2891 5754/0482 677 281

How to be aligned with MSHHS

- Participate in an AM1 event if not already completed and undertake further training every 3 years.
- Case based and practical learning with our GP and specialist colleagues, as well as the Midwifery teams, Perinatal MH Team, and Allied Health.
- Attend event (5-6hrs) and feedback questionnaire (3 x evening events in MSHHS).
- Alignment will need to be undertaken (or an alternative) every 3 years.

Maintaining Alignment

To maintain alignment after 3 years, you must either:

- repeat one Alignment Seminar - you can repeat a MSHHS Alignment

OR an affiliated Alignment (MMH/RBWH/Nambour/West Moreton/GCUH) + complete the online bridge including Q&A.

OR

- attend six hours of relevant antenatal or postnatal/neonatal CPD education and complete online bridge including Q & A. The CPD events DO NOT need to be with the Metro South Health Services

OR

- Complete a RANZCOG Diploma or Certificate in Women's Health + complete the online bridge

AM1.3 planned for early August – Early Pregnancy Problems

MSH Maternity Shared Care Online Bridging Programme

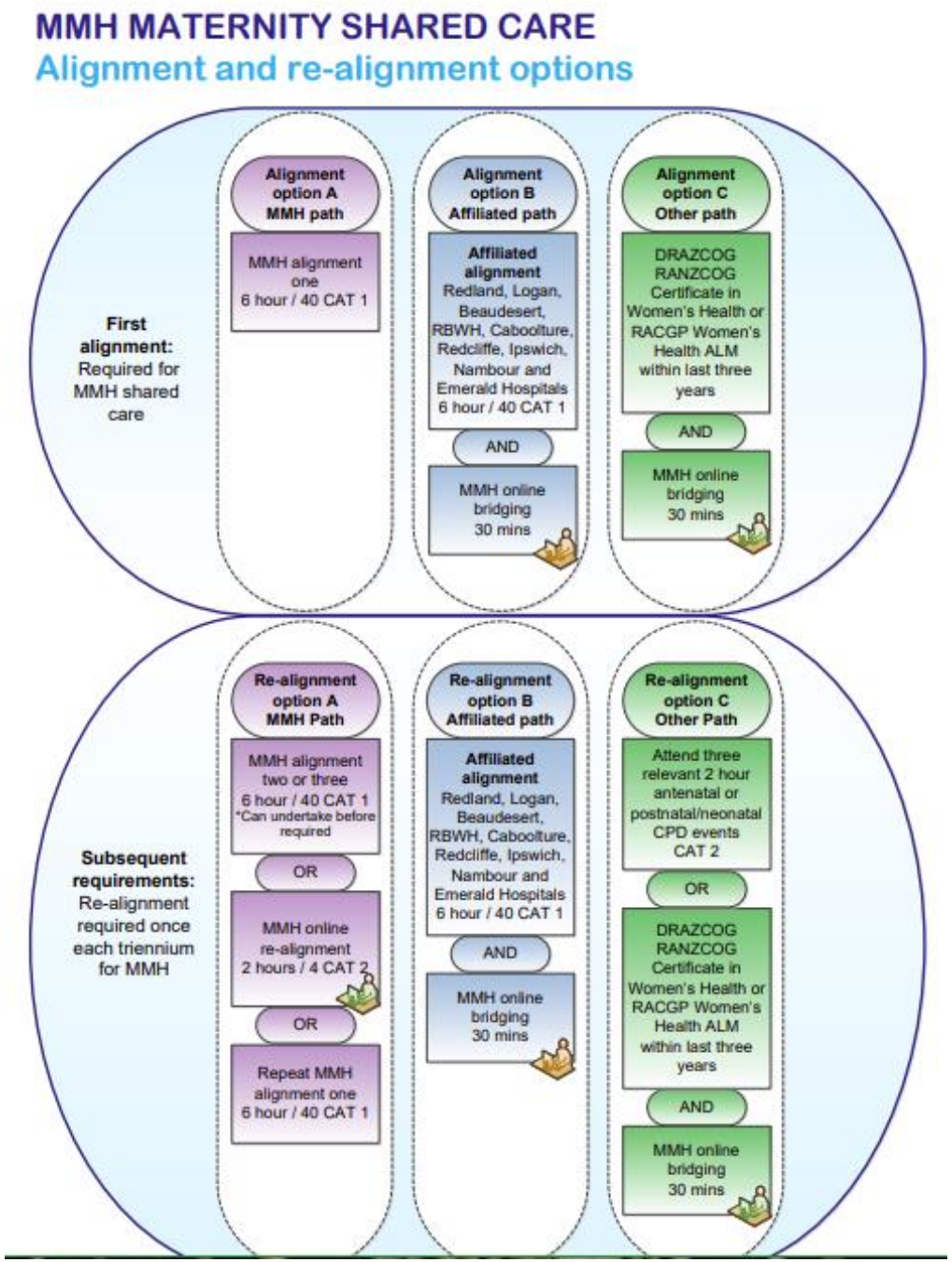
- Programme is delivered via an interactive online learning module including an exam/quiz to complete.
- Available to GPs who are currently aligned to Shared Care at MMH (or an alternative SEQ Alignment) and wish to align with MSH.
- Takes approximately 1- 1 ½ hours to complete.
- Once complete, GPs will receive notice of completion which can be claimed as Continuing Professional Development (CPD), logged through the RACGP member portal or other associations.
- To access the MSH GP Maternity Shared Care Online Bridging Program, please email us on GPLO_Maternity_Share_Care@health.qld.gov.au

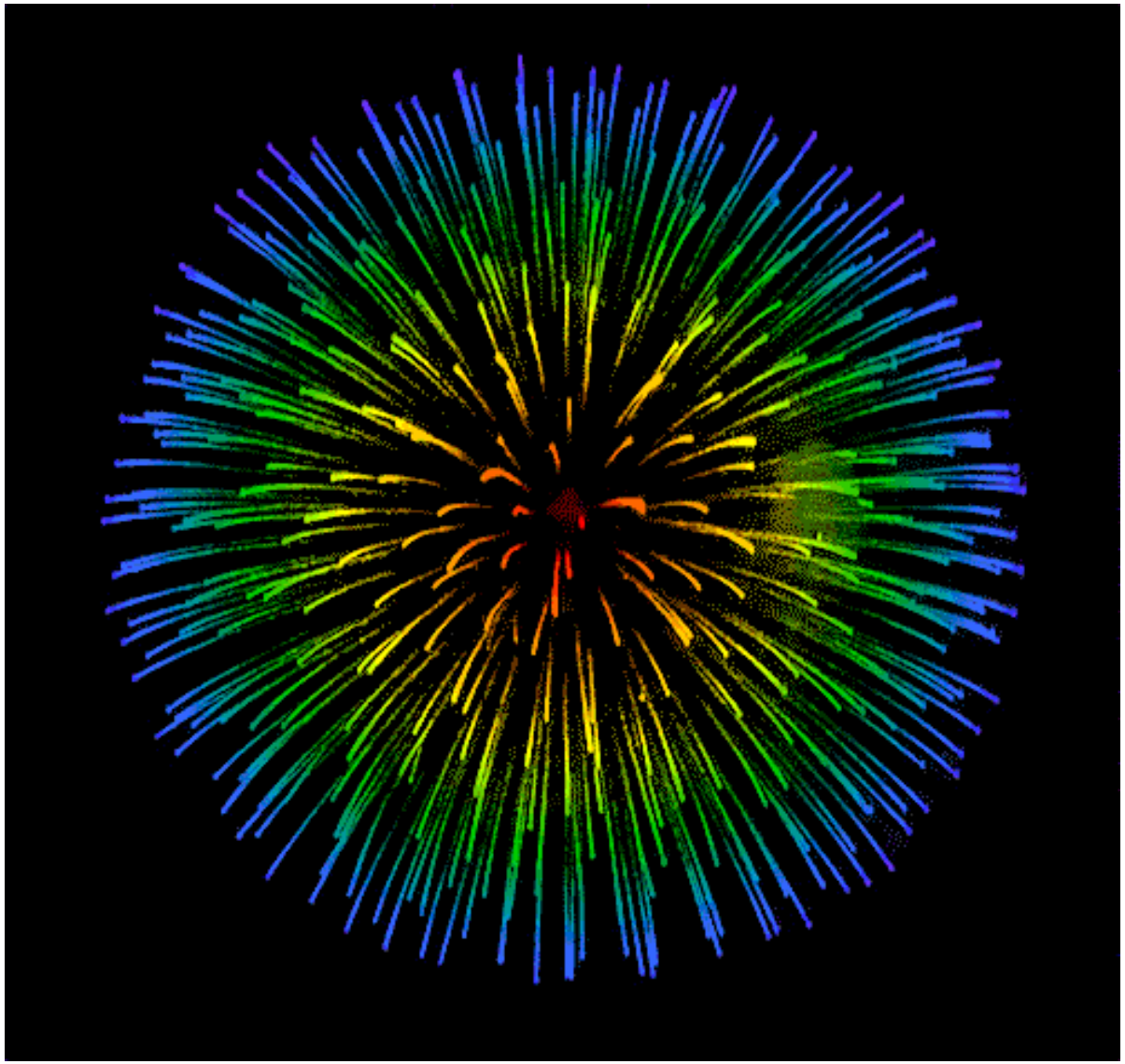
MMH Alignment

- To become aligned with MMH you can participate in an Alignment event run by MMH (AM1/AM2/AM3 and soon to be AM4)

OR

- after a MSHHS Alignment, GPs will need to complete MMH's online bridge including Q&A – accessed by contacting the MMH Alignment team and forwarding a copy of your certificate from completion of this event.
- MMH GP Liaison Midwife - Telephone 07 3163 1861, mobile 0466 205 710 or email GPL@mater.org.au





Enjoy the remainder of your weekend!