Metro South Health

Quality healthcare every day

Metro South Health and Hospital Service

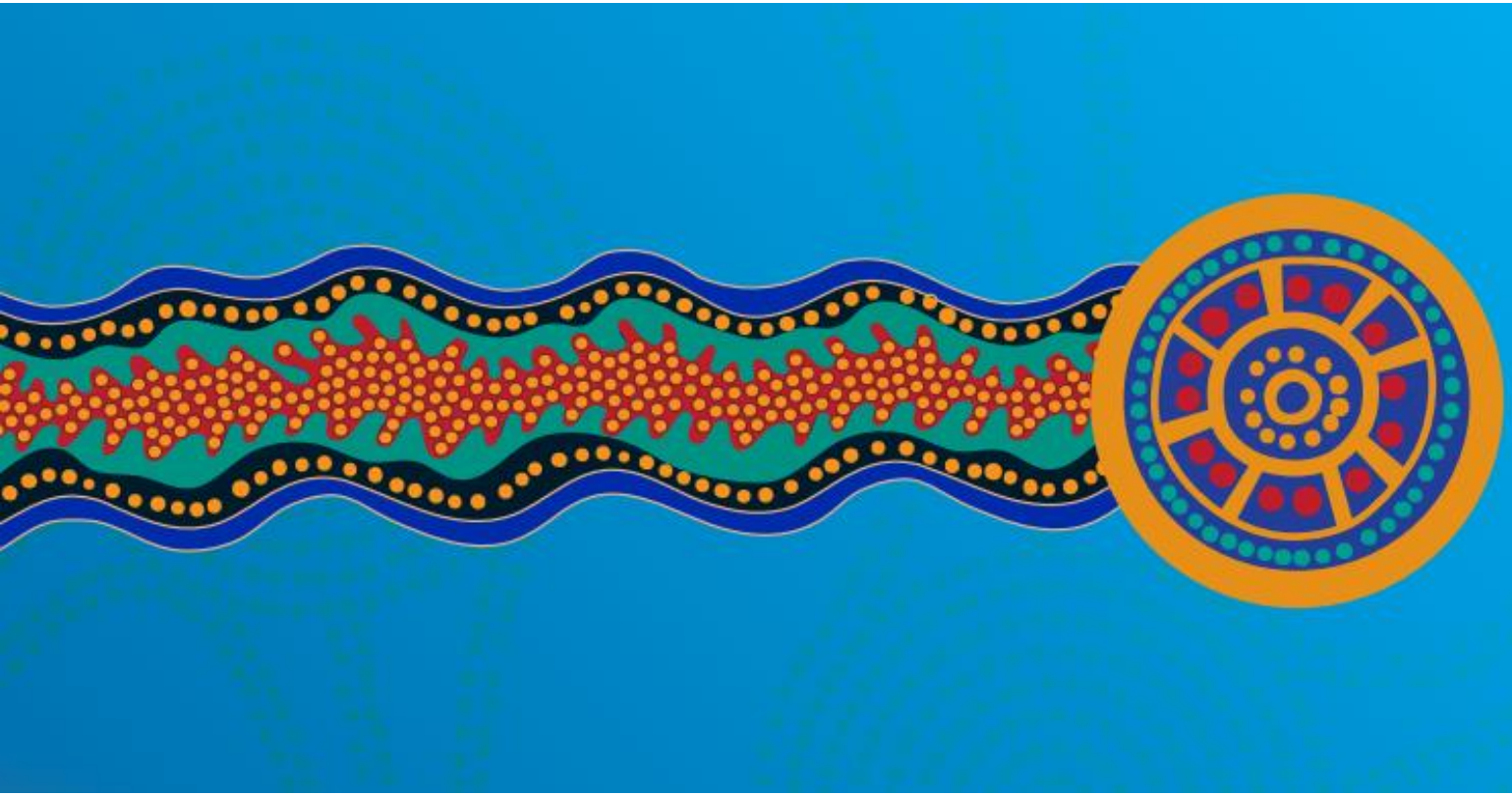
GP Gynaecology Education Day

26th October 2024

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
- Lisa Miller, GPLO Midwife Manager

Acknowledgments

- Metro South Health and Hospital Service
- Maternity Services at Logan/Beaudesert/Redland Hospitals for their clinical input and support
- Yourselves

- And a big THANK YOU to our sponsor today – Queensland Fertility Group and the Brisbane South Private Hospital

From Logan, Beaudesert, and Redland Hospital Teams

- Dr Hasthika Ellepola
- Dr Prem Gill
- Dr Sanja Savic
- Melanie Walkenhorst
- Nicole Price
- Dr Mugundan Achari
- Dr Stephanie Galibert
- Dr Shauna Peck

+ Guest Presenters:

- Dr Andy Perry (Clontarf GP/Marie Stopes International & BSPH GynaeHealth)
- Dr YuHwee Tan, Urogynaecologist Queensland Pelvic Floor Services (QPFS) at Greenslopes Hospital and Gold Coast HHS and the Queensland Pelvic Mesh Service

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.

For self reflection throughout case-based discussions

For CPD self-reporting - Reviewing Performance Gynae GP Education Day - Sat 26th October 2024

Red Case	**Green Case**	**Pink Case**
3 Things Learnt	3 Things Learnt	3 Things Learnt
1.	1.	1.
2.	2.	2.
3.	3.	3.
How will your patient care change?	How will your patient care change?	How will your patient care change?

Session 1

Time	Session name	Presenter	Delivery
8:00 am	Welcome, Housekeeping, learning objectives.	Dr Kim Nolan	GP Facilitator
8:20 am – 8:40 am	Task 1 Breakout groups – Case Discussion	Breakout	Facilitated groups
8:40 am	Case Discussion – ToP	Group Spokesperson Dr Andy Perry Nicole Price	Facilitated groups Power Point Presentation & Forum Discussion
9:20 am	Case Discussion – Abnormal Cervical Screening Test Follow Up	Group Spokesperson Dr Sanja Savic Dr Kim Nolan	Facilitated groups Power Point Presentation & Forum Discussion
10.00 am	Case Discussion – Heavy Menstrual Bleeding	Group Spokesperson Dr Kim Nolan Dr Hasthika Ellepola	Facilitated groups Power Point Presentation & Forum Discussion
10:40 am	Morning Tea	ALL	ALL

Session 2

Time	Session name	Presenter	Delivery
11.00 am	Case Discussion – Menopause Management	Group Spokesperson Dr Prem Gill	Facilitated groups Power Point Presentation & Forum Discussion
11:40 am	Case Discussion – Pelvic Floor Prolapse	Group Spokesperson Dr YuHwee Tan	Facilitated groups Power Point Presentation & Forum Discussion
12:10 pm	Case Discussion – Incontinence	Group Spokesperson Dr YuHwee Tan	Facilitated groups Power Point Presentation & Forum Discussion
12:40 pm	Case Discussion – Pelvic Pain/Endometriosis	Group Spokesperson Dr Hasthika Ellepola	Facilitated groups Power Point Presentation & Forum Discussion
1:15 pm	LUNCH	ALL	ALL

Session 3

Time	Session name	Presenter	Delivery
2:00 pm	Physiotherapy Management of Prolapse, Urinary and Faecal incontinence; Physiotherapy Pelvic Health Service in MSHHS	Melanie Walkenhorst	Practical Demonstration ALL
2:15 pm	Hands-On Practical Demonstrations - Vaginal Pessaries - Speculum Use - Implanon Insertion - IUD Insertion - Pipelle Biopsy Demo - Endometrial Ablation Demo	Breakout Group Rotations	Facilitated groups Power Point Presentation & Forum Discussion
3:45 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 and ToP referrals, and recommended pathways.
- Improved knowledge of guidelines and resources that can assist GPs in care of their gynaecology patients.

Red Group: Jade

- 26-year-old multiparous G5 P3 at 8 weeks pregnant.
- History of Postnatal depression treated sporadically with SSRI; high alcohol use at times; Smokes 10-15 cigarettes/day
- Unplanned pregnancy and considering a termination of pregnancy.
- Department of Child Safety involvement in the past, but you are unsure of the current situation

Set out your initial assessment and referrals.

Metro South Health

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Termination of Pregnancy

Dr Andy Perry
GP and Marie Stopes International Medical Officer
Locum Work Gynaehealth (https://www.gynaehealth.com.au)

ICARE² values

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Conscientious Objectors:

Where a health practitioner conscientiously objects to ToP care, they must disclose their objection, and they have a professional responsibility and legal requirement to ensure transfer of care without delay to a health practitioner or service who they believe can provide the requested service.

We believe that all clinicians who may encounter a patient considering a pregnancy termination need to have knowledge of the options available to patients, and we invite all to be involved in this case discussion.

In an emergency situation, medical and clinical staff cannot conscientiously object to providing care following a failed early medical termination. All Hospital and Health Services will provide services to women who present for emergency care.

Termination of pregnancy

Termination of Pregnancy Act 2018

- Lawful termination may be performed by registered medical practitioners
- Up to gestational limit of 22 + 0, for any reason
- Gestation upward of 22+1; 2 x medical practitioner agreement that termination can be performed
- GPs advised to contact Obstetrician on Call or Nurse Navigator for ToP service to assist these patients

Fast facts about termination of pregnancy

Half of Australian women will experience an unplanned pregnancy in their lifetime.

Between 10,000 and 14,000 terminations are performed in Queensland each year.

Most terminations are performed in the first trimester (up to 12 weeks) in the private sector.

While termination of pregnancy is one of the most common procedures performed for women, it can be inaccessible, expensive and heavily stigmatised.

By positioning termination of pregnancy as a health issue rather than a legal issue, the Act:

supports a woman's right to health including reproductive health and autonomy

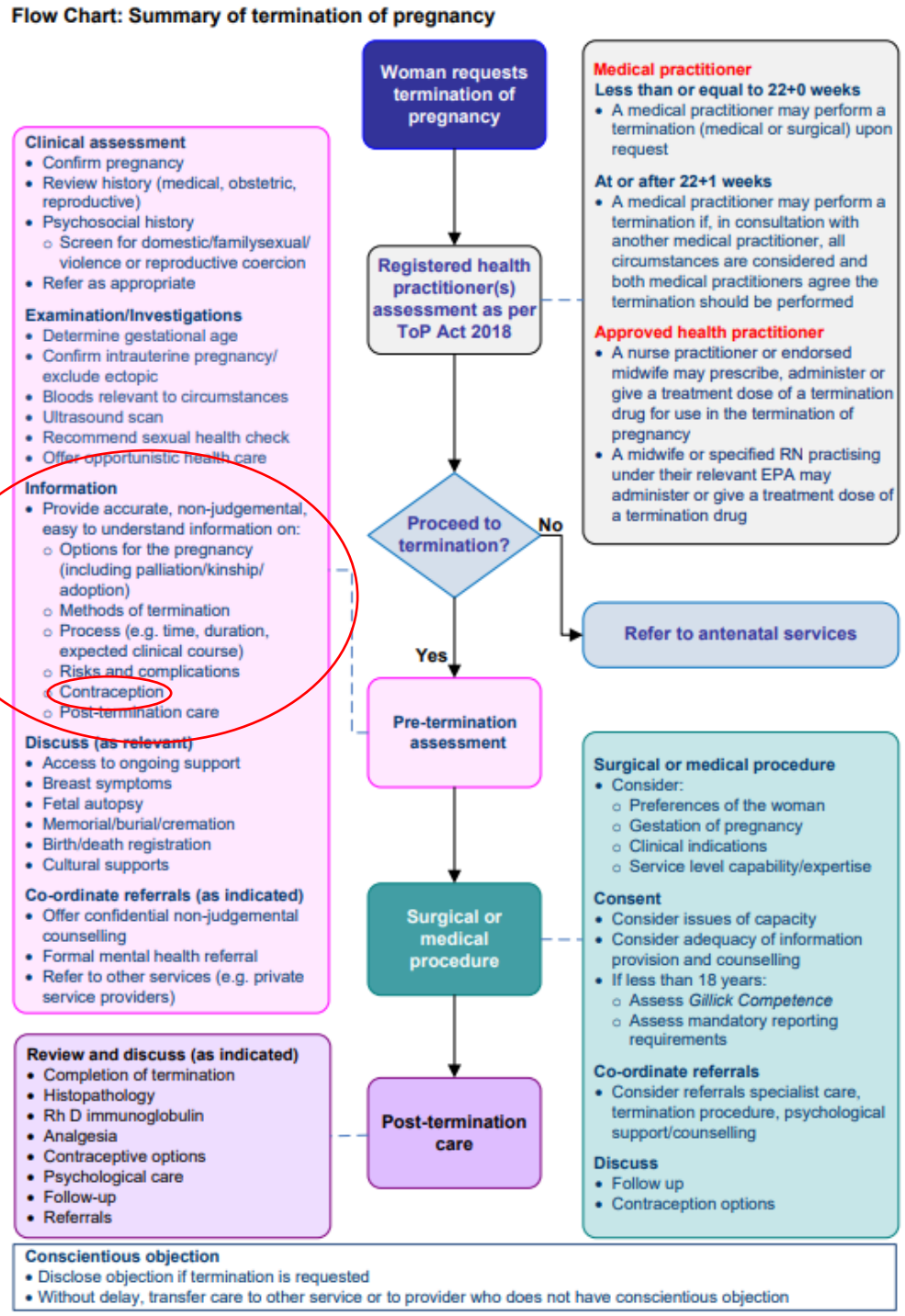
provides clarity and safety for health practitioners providing terminations of pregnancy

brings Queensland legislation in line with other Australian jurisdictions.

Enabling safety framework supporting changes to prescribing a registered termination of pregnancy drug, such as **MS 2 Step**

Queensland Health has heard from GP peak bodies that many GPs are not confident in prescribing MS-2 Step.

To support improved availability and access to early medical termination of pregnancy, in developing any additional education and training resources, Queensland Health should ensure as far as possible that they are also made available to GPs.

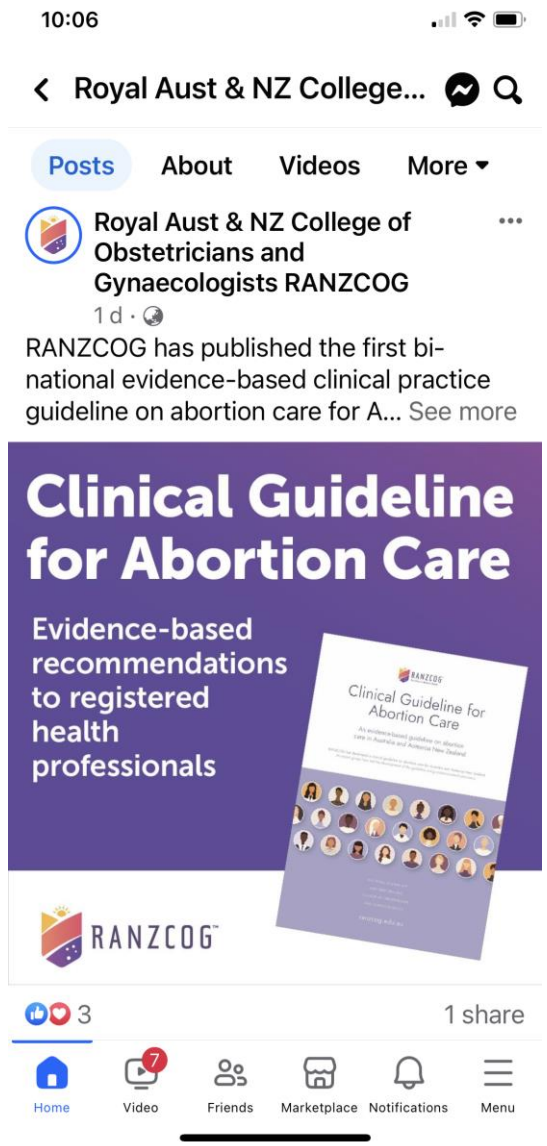


Guideline: Termination of pregnancy (health.qld.gov.au)

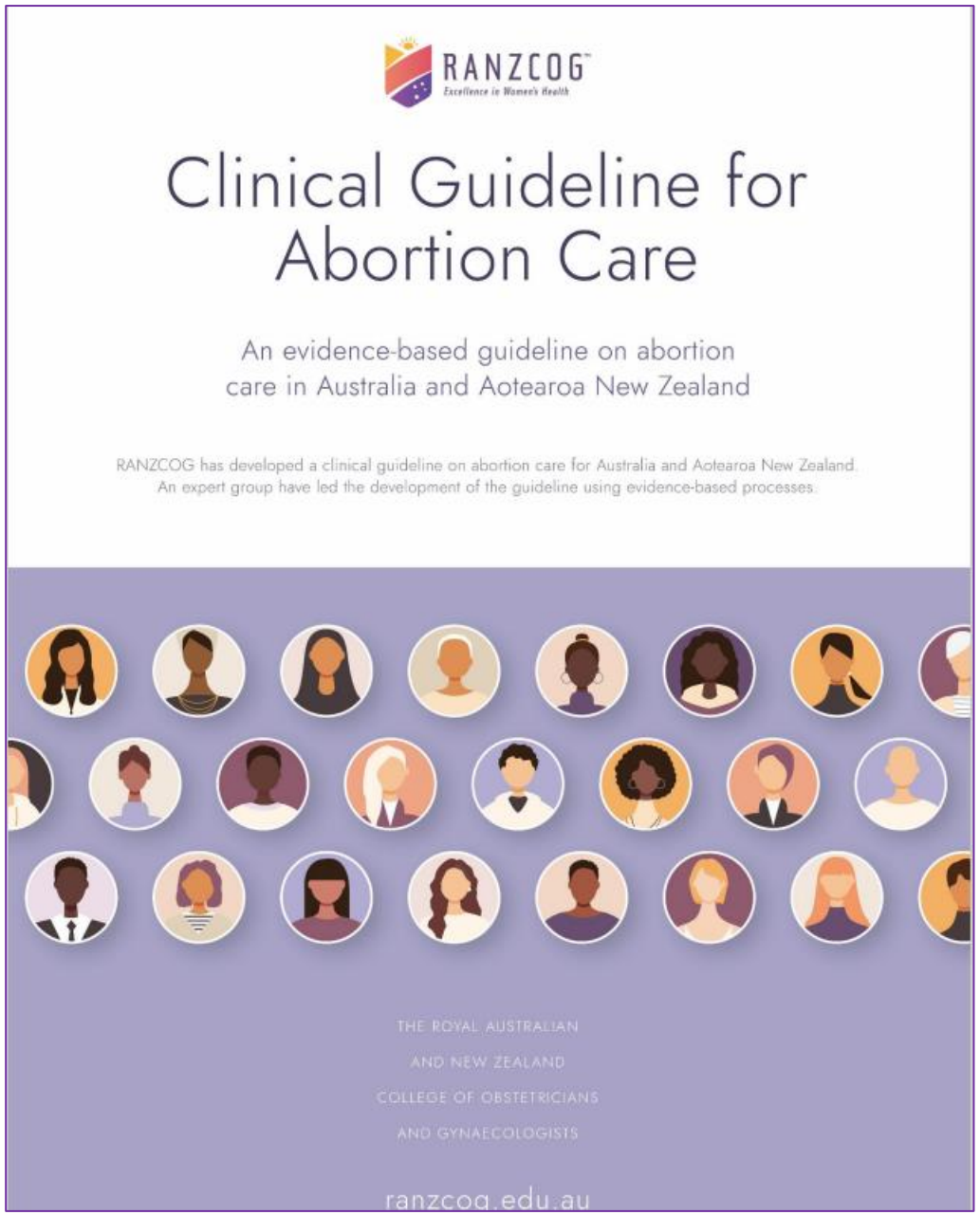
- Australia has a relatively high rate of unintended pregnancy (19.7 per 1000 women aged 15–44 years).
- Australia ranks amongst the highest countries for termination of pregnancy in the developed world with 1 in 4 women undergoing a termination procedure.

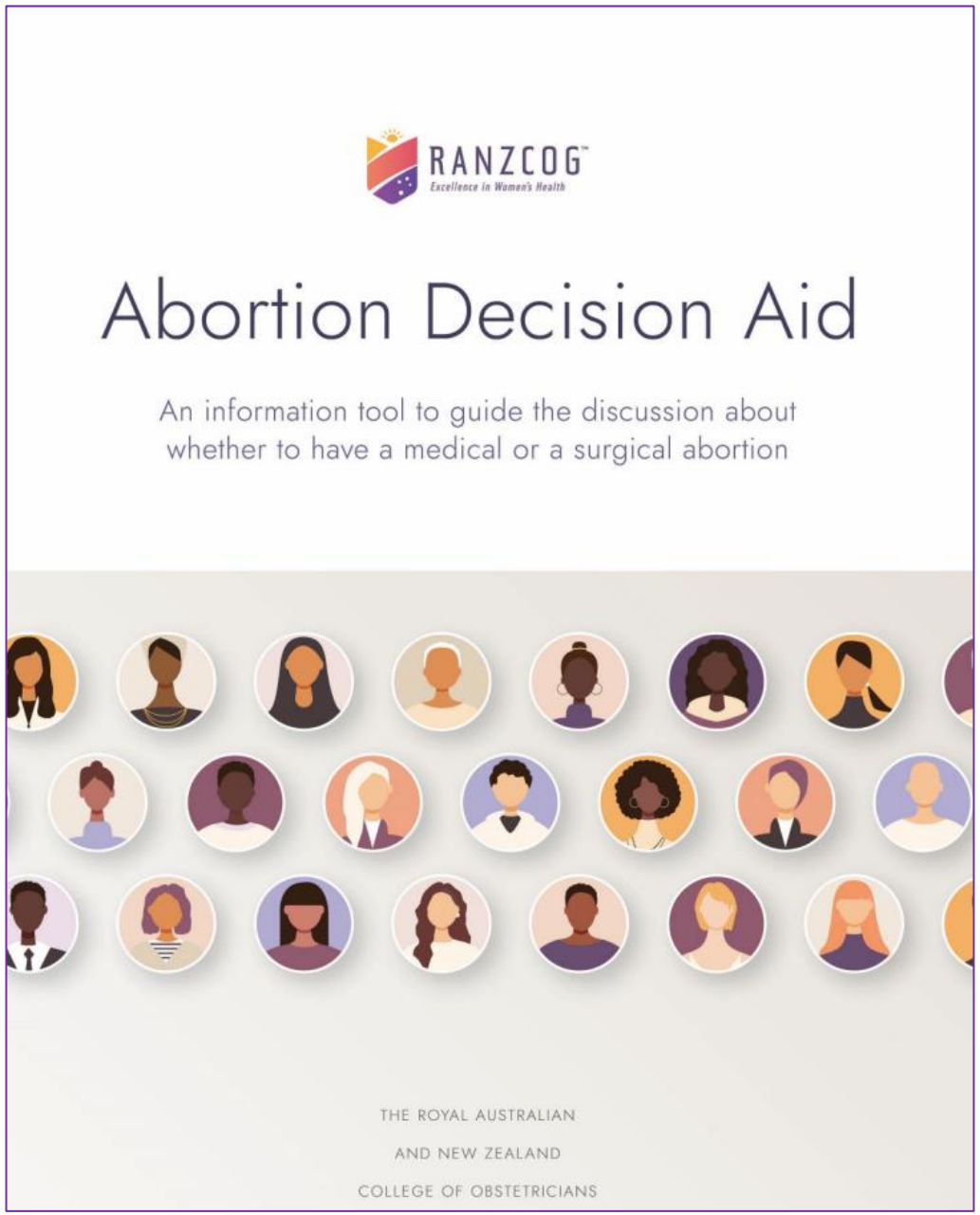
https://www.health.qld.gov.au/__data/assets/pdf_file/0029/735293/g-top.pdf

RANZCOG – Clinical Guideline for Abortion Care and Patient Resource Launch – 30th October 2023



https://ranzcog.edu.au/resources/abortion-guideline/





[Clinical Guideline for Abortion Care - RANZCOG]

Termination of Pregnancy – MS 2 Step

For gestation ≤ 9 weeks (63 days), GP management with MS 2 Step is appropriate

- MS 2 Step prescribing is now available to all GPs from August 2023
- Pregnancy must be confirmed to be intrauterine and ≤ 9 weeks (63 days) on USS
- For recognised training, go to https://www.ms2step.com.au/
- or see GP to GP referrals page on Brisbane South Health Pathways
- Prescribing MS-2 Step Health Pathways now available.

MS2-Step

- For women ≤9 weeks gestation (63 days gestation)
- Mifepristone/ Misoprostol combination
- Day 1 - Mifepristone turns off progesterone
- 36-48 hours after - Misoprostol induces uterine contractions to expel POC
- Follow up plan in place

5.10 Medical or surgical abortion and pain relief

Good Practice Point 11

The guideline development group recommends that analgesia for surgical or medical abortion should be individualised to patient preferences, clinical need, clinician capabilities, local policies and/or contextual factors.

5.10.1 Pain relief up to 14 weeks pregnant

Recommendation 14 Evidence-based recommendation Strong

For surgical abortion up to 14 weeks pregnant offer combination of:

- Pre-procedure analgesia with non-steroidal anti-inflammatory (NSAID) medications
- Conscious or deep sedation with the possible addition of paracervical block

GRADE of evidence: Moderate

Good Practice Point 12

For surgical abortion up to 14 weeks pregnant, general anaesthesia could be offered if clinically indicated or patient preference.

Recommendation 15 Evidence-based recommendation Strong

For medical abortion up to 14 weeks pregnant offer a single dose ibuprofen 1600 mg (off-label use), followed by ibuprofen 400 mg to 600 mg eight-hourly. A maximum dose of ibuprofen 2400 mg can be taken in 24 hours while symptoms of pain persist.

GRADE of evidence: Moderate

Good Practice Point 13

For medical abortion up to 14 weeks pregnant, pain relief can be optimised by:

- Offering paracetamol (1000 mg 4 to 6 hourly as required with a maximum 4000 mg per 24 hours) in addition to ibuprofen with antiemetic 30 minutes prior to administration of misoprostol
- Considering selective use of opiate analgesia

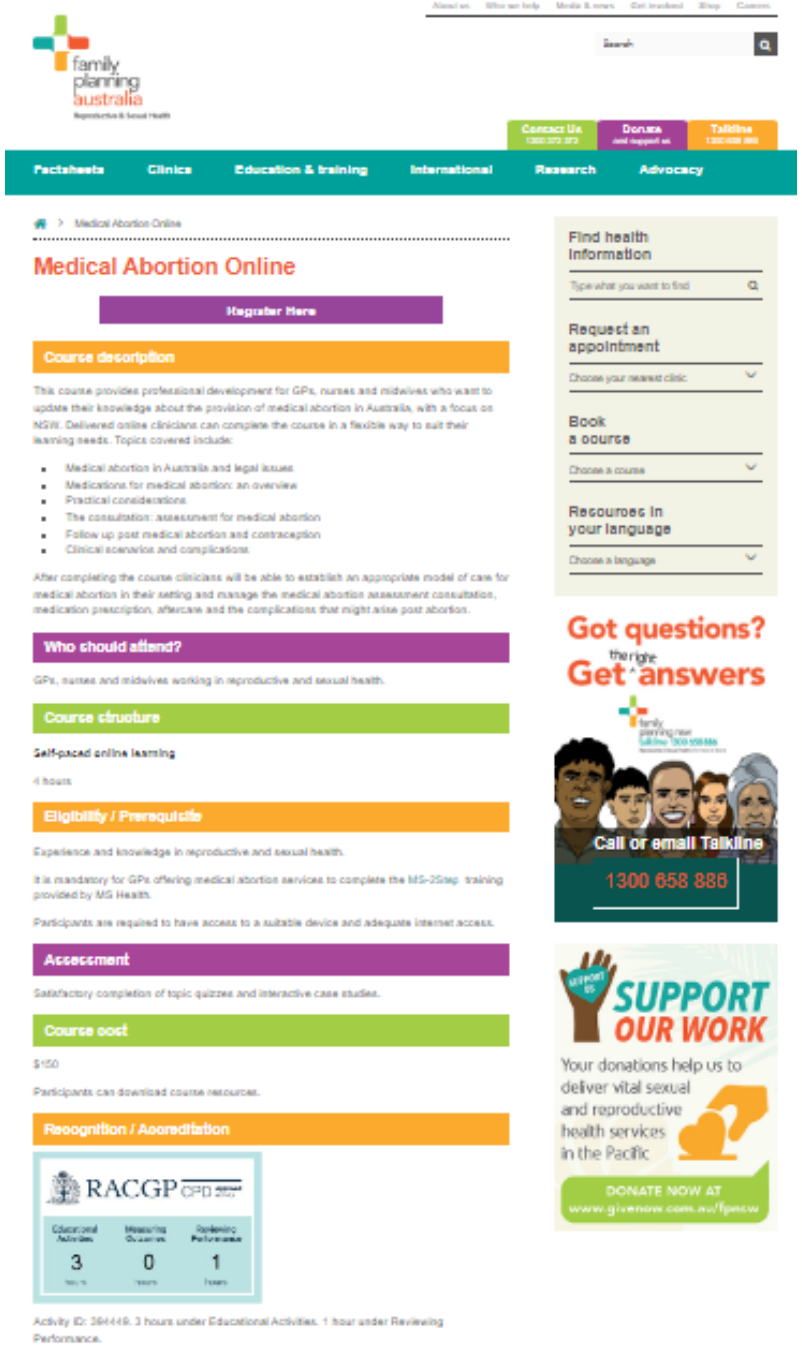
First recommendations for pain management in ToP + antiemetic use prior to mToP - RANZCOG

Online Resources and Education:

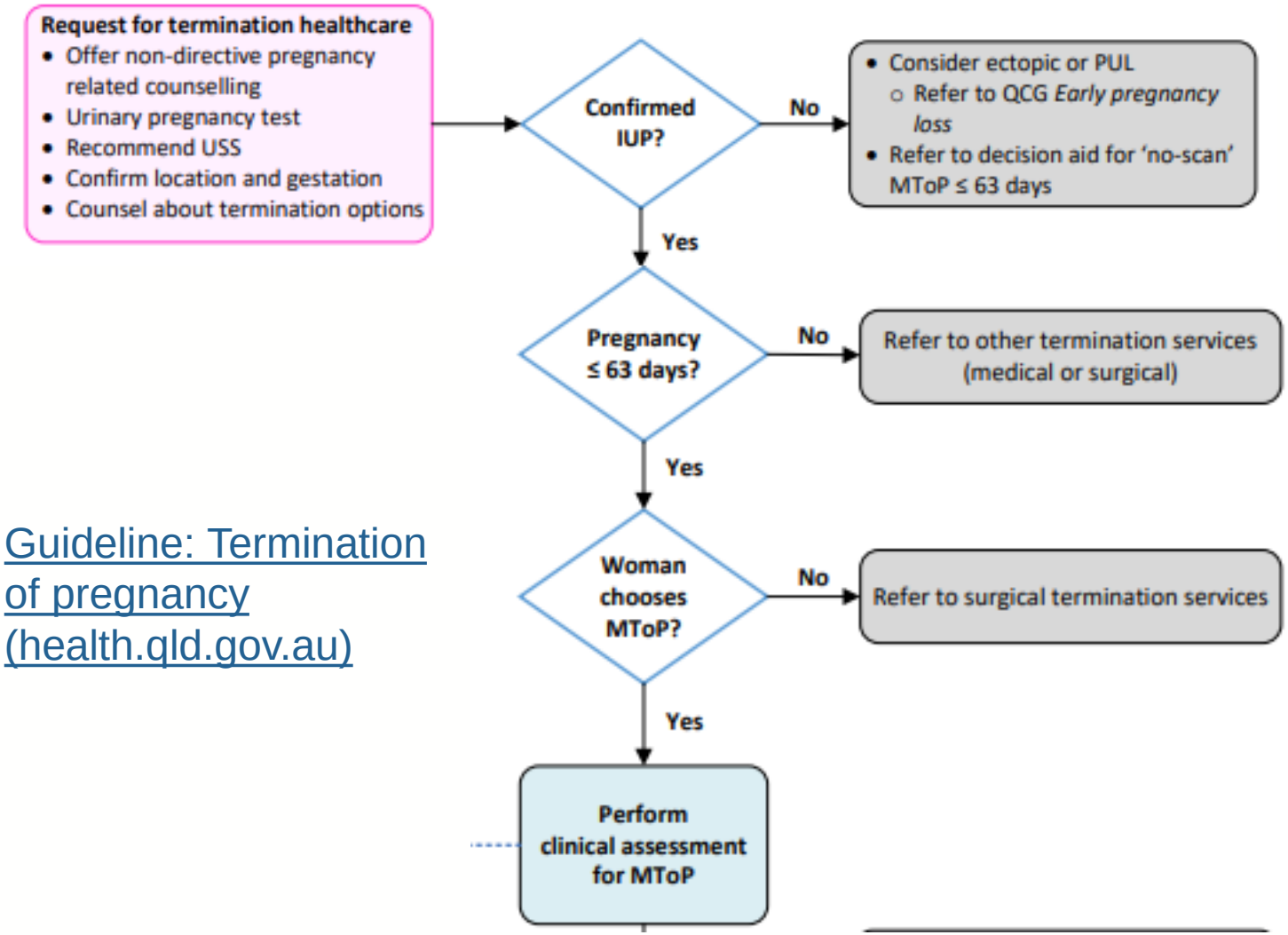
- Online training and resources provided by MS Health on MS-2step for registered health practitioners to enable them to understand the pharmacology and prescribe the medication
- "Prescribing MS-2 Step" – Brisbane South Health Pathways
- Queensland Health Termination of Pregnancy Clinical Guideline and Presentation, which are intended to provide evidence-based information and guide clinical practice.
- Termination of Pregnancy knowledge assessment (self-directed learning tool)

https://www.fpnsw.org.au/education-training/courses-clinicians/9-medical-abortion-online

Family Planning NSW have a Medical Abortion online course for GPs, nurses and midwives: 4 hours



Flowchart: Medical termination at or less than 63 days of pregnancy



[Guideline: Termination of pregnancy (health.qld.gov.au)]

Clinical assessment

- Review history (medical, reproductive and obstetric)
- Psychosocial history
  - Refer as appropriate
- Exclude contraindications
- Seek written consent
- Remove IUD
- Discuss contraception
- Consider need for bloods
- Recommend sexual health check
- Offer opportunistic health care
  - Cervical screening test
  - Smoking cessation advice
  - Substance use
- Refer as indicated to other services

Self administration of medication

- Provide instructions (how/when)
- Advise on:
  - Expected pain and bleeding
  - Pain management
  - Potential complications/side effects
  - Availability of support person
  - Importance of follow-up
  - Accessing emergency care
  - Actions if no onset of bleeding within 24 hours after misoprostol
  - Contraception commencement
  - Fertility and resuming sexual activity
  - Availability of counselling or specialist support services

6. Arrange investigations ^ if not already done.

Investigations

- Ultrasound to confirm location of pregnancy and determine gestational age v.
- Quantitative beta hCG ≤ 24 hours before taking mifepristone (step 1) if using quantitative beta hCG to ensure completion of MTOP at follow-up v.
- Chlamydia and gonorrhoea PCR (low vaginal self-swab is appropriate). Note that STI screening should not delay providing timely abortion care.
- Other sexually transmitted infection (STI) checks, as indicated.
- FBC, ferritin, E/LFT if suspicion of underlying haematological, renal, or hepatic abnormalities.
- Blood group if patient suspected to be > 10 weeks' gestation.
- Cervical screening, if appropriate and not up to date.

7. Assess if the patient meets the eligibility criteria ^.

Eligibility criteria

To be eligible for a MTOP in the community, a patient must:

- provide informed voluntary consent.
- have an intrauterine pregnancy v up to 63 days' (9 weeks') gestation.
- have no medical contraindications.
- stay for 14 days within two hours of a 24-hour emergency department capable of managing complications.
- have a support person present for 24 hours after taking misoprostol (step 2).

Prescribing MS-2 Step

https://brisbanesouth.communityhealthpathways.org/17305.htm

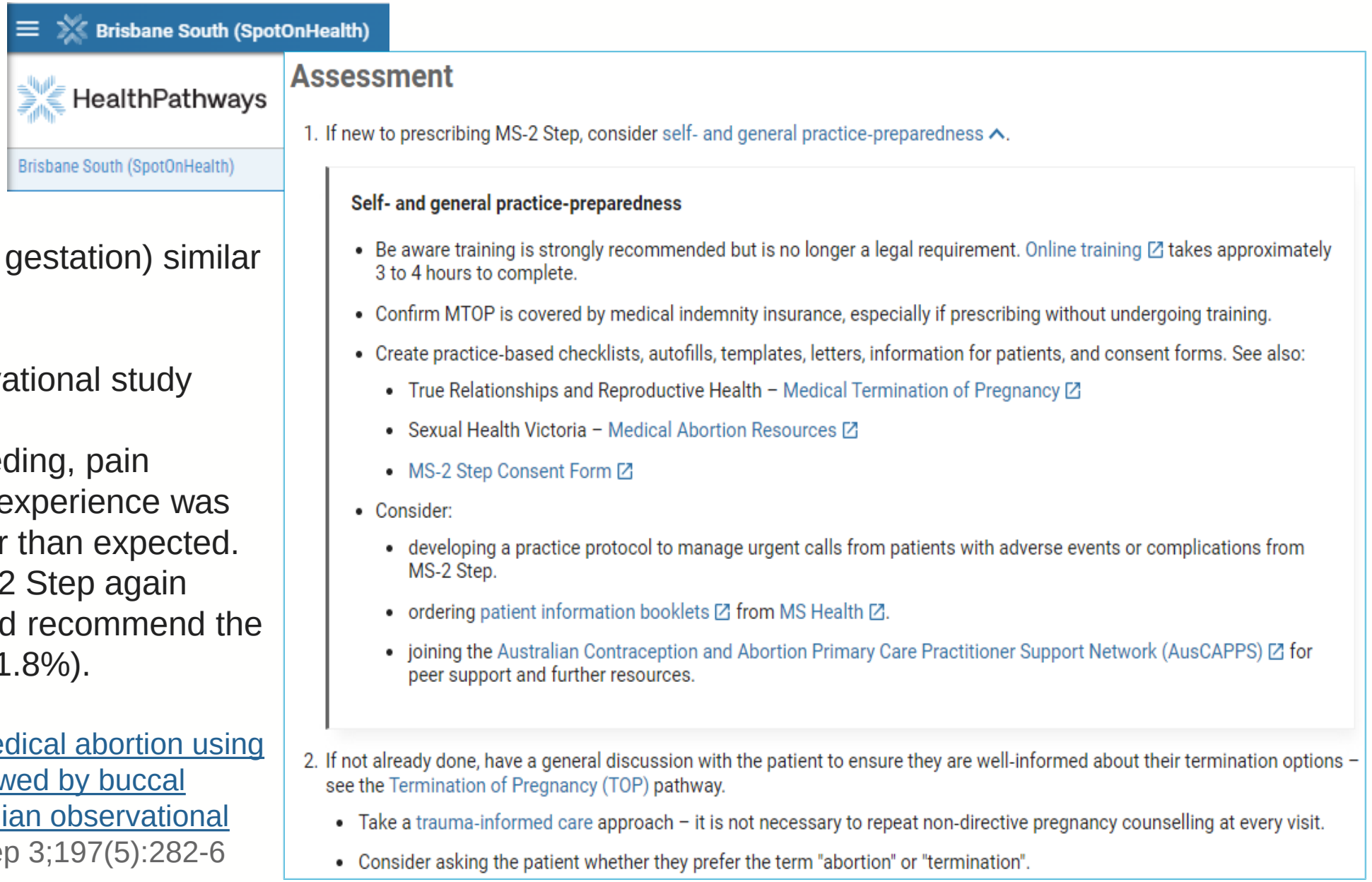
Prescribing MS-2 Step

Early MTOP (≤ 63 days' gestation) similar to a miscarriage.

Australian based observational study concluded

- many people felt bleeding, pain /cramps, and overall experience was as expected, or better than expected.
- Many would use MS-2 Step again (78%) and most would recommend the method to a friend (91.8%).

Goldstone P et al. Early medical abortion using low-dose mifepristone followed by buccal misoprostol: a large Australian observational study. Med J Aust. 2012 Sep 3;197(5):282-6



Important Considerations

- Is your patient under 16 years of age?
  - Consider independent counselling & ensure there is a support person who is available and engaged
  - 14 years and above require assessment for Gillick competence and social work input (in MSHHS setting)
  - Request termination of pregnancy from the public hospital for multidisciplinary assessment and support if the patient is:
    - aged < 14 years.
    - aged < 18 years and not Gillick competent.
    - an adult lacking capacity
  - In paediatric and adolescent patients: consider referral to Queensland Statewide Paediatric and Adolescent Gynaecology Service at QCH/RBWH
- Assessment and screening for domestic violence, sexual assault & reproductive coercion is important. Each woman should be asked how she is feeling, if she is safe and if she has been forced into making this decision
- Support services available to the woman to aid in decision making due to circumstance (e.g., Children by Choice, SANDS)

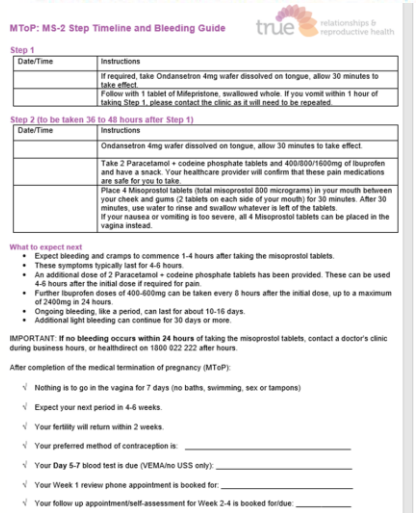
Prescribing

1. Obtain written informed consent for the procedure and advise the patient on what to expect.
2. Arrange medications for MTOP:
   - Prescribe the following:
     - MS-2 Step
     - An antiemetic

Antiemetic

- Consider prescribing an antiemetic e.g., metoclopramide 10 mg orally or ondansetron 4 mg, taken 30 to 60 minutes before mifepristone (step 1) and misoprostol (step 2). Additional antiemetics can be taken if required (as per usual dosing instructions).
- Check full prescribing data, dosage, drug interactions, and contraindications when prescribing.

     - Analgesia
   - Give the patient clear instructions on how to take the medications.
   - Consider the use of an MS-2 Step Timeline and Bleeding Guide.



MToP: MS-2 Step Timeline and Bleeding Guide

Step 1

Date/Time	Instructions
	If required, take Ondansetron 4mg wafer dissolved on tongue, allow 30 minutes to take effect.
	Follow with 1 tablet of Mifepristone, swallowed whole. If you vomit within 1 hour of taking Step 1, please contact the clinic as it will need to be repeated.

Step 2 (to be taken 36 to 48 hours after Step 1)

Date/Time	Instructions
	Ondansetron 4mg wafer dissolved on tongue, allow 30 minutes to take effect.
	Take 2 Paracetamol + codeine phosphate tablets and 400/800/1600mg of Ibuprofen and have a snack. Your healthcare provider will confirm that these pain medications are safe for you to take.
	Place 4 Misoprostol tablets (total misoprostol 800 micrograms) in your mouth between your cheek and gums (2 tablets on each side of your mouth) for 30 minutes. After 30 minutes, use water to rinse and swallow whatever is left of the tablets. If your nausea or vomiting is too severe, all 4 Misoprostol tablets can be placed in the vagina instead.

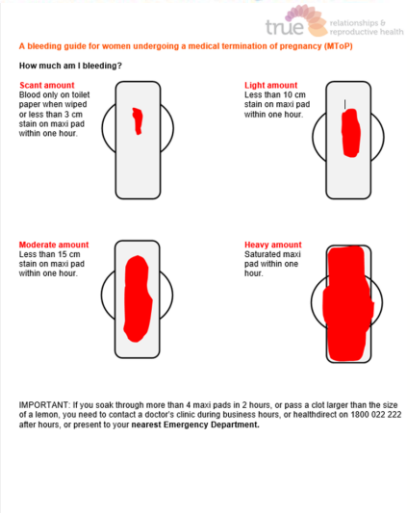
What to expect next

- Expect bleeding and cramps to commence 1-4 hours after taking the misoprostol tablets.
- These symptoms typically last for 4-6 hours.
- An additional dose of 2 Paracetamol + codeine phosphate tablets has been provided. These can be used 4-6 hours after the initial dose if required for pain.
- Further Ibuprofen doses of 400-600mg can be taken every 8 hours after the initial dose, up to a maximum of 2400mg in 24 hours.
- Ongoing bleeding, like a period, can last for about 10-16 days.
- Additional light bleeding can continue for 30 days or more.

IMPORTANT: **If no bleeding occurs within 24 hours** of taking the misoprostol tablets, contact a doctor's clinic during business hours, or healthdirect on 1800 022 222 after hours.

After completion of the medical termination of pregnancy (MToP):

- √ Nothing is to go in the vagina for 7 days (no baths, swimming, sex or tampons)
- √ Expect your next period in 4-6 weeks.
- √ Your fertility will return within 2 weeks.
- √ Your preferred method of contraception is: _____
- √ Your **Day 5-7** blood test is due (VEMA/no USS only): _____
- √ Your Week 1 review phone appointment is booked for: _____
- √ Your follow up appointment/self-assessment for Week 2-4 is booked for/due: _____



A bleeding guide for women undergoing a medical termination of pregnancy (MToP)

How much am I bleeding?

Scant amount
Blood only on toilet paper when wiped or less than 3 cm stain on maxi pad within one hour.

Light amount
Less than 10 cm stain on maxi pad within one hour.

Moderate amount
Less than 15 cm stain on maxi pad within one hour.

Heavy amount
Saturated maxi pad within one hour.

IMPORTANT: If you soak through more than 4 maxi pads in 2 hours, or pass a clot larger than the size of a lemon, you need to contact a doctor's clinic during business hours, or healthdirect on 1800 022 222 after hours, or present to your **nearest Emergency Department.**

3. Make arrangements to ensure the pregnancy has been successfully terminated.

Arrangements to ensure the pregnancy has been successfully terminated

- If using quantitative beta HCG to ensure completion of MTOP at follow-up:
  - provide the patient with pathology request forms, if not already done.
  - check for adequate drop in beta hCG levels.

Adequate drop in beta hCG levels

The patient does not have a continuing viable pregnancy if beta hCG levels taken 7 to 14 days apart drop by ≥ 80%. Do not expect the beta hCG levels to return to zero in this time.

- If using urinary beta hCG, consider providing the patient with a low-sensitivity urinary beta hCG test (e.g., Check4-hCG) to do at home, or rebook the patient for a test at the practice.

Australian guidelines from the National Blood Authority and RANZCOG: recommend that with mToP < 10 weeks' gestation there **is insufficient evidence to suggest the routine use of Rh D immunoglobulin.**

5.3 Testing prior to an abortion

5.3.1 Abortion without prior testing of haemoglobin, Rh D status

Recommendation 3 — Consensus-based recommendation

Routine testing of haemoglobin is not required prior to abortion.

Recommendation 4 — Consensus-based recommendation

Routine testing of blood group for Rh D status, up to 10 weeks pregnant for either medical or surgical abortion, is not required prior to abortion.

Good Practice Point 3

Clinical judgement should be used to evaluate selective testing of haemoglobin and blood group prior to abortion in women at increased risk of haemorrhage, including but not limited to anaemia or advanced gestation.

Good Practice Point 4

Anti-D[58] administration is recommended for abortion in pregnancies 10 weeks or more for Rh D negative women. Individualised care based on an individual's risk-benefit profile could be considered.

https://ranzcog.edu.au/resources/abortion-guideline/

6 ADMINISTRATION OF MS-2 Step (mifepristone, misoprostol)

6.1 Assessment of Gestational Age

All patients requesting termination of pregnancy must have an accurate assessment of their gestational age. Gestational age may be assessed by the patient's menstrual history, physical examination, or ultrasound. It is recommended that the duration of pregnancy be confirmed by ultrasound. In the event that an ultrasound is not possible, extra caution should be exercised. If there is any doubt about the age of the pregnancy from the patient's menstrual history, symptoms or physical examination, an ultrasound must be performed to confirm gestational age. Gestational age is calculated from the first day of the LMP. If the patient's menstrual history, symptoms, physical examination, or ultrasound raises suspicion of ectopic pregnancy, this must be excluded before treatment is started.

6.2 Rhesus Determination

The need for Rhesus determination and prevention of Rhesus alloimmunisation in Rh D negative patients should be assessed in line with the current clinical guidelines for induced abortions.

Australian guidelines from the National Blood Authority[58] and Royal Australian and New Zealand College of Obstetricians and Gynaecologists[59] recommend that in the setting of medical termination of pregnancy before 10 weeks of gestation there is insufficient evidence to suggest the routine use of Rh D immunoglobulin.

6.2 Screening for Lower Genital Tract Infections

Patients should be screened for *Chlamydia trachomatis* before MS-2 Step (mifepristone, misoprostol) treatment. In asymptomatic patients, treatment need not be deferred while waiting for screening results.

MSH-Training-Manual-MS-2-Step-2023-07-25.pdf (ms2step.com.au)

AusCAPPS | Medcast

ABOUT THIS NETWORK

Our project and mission

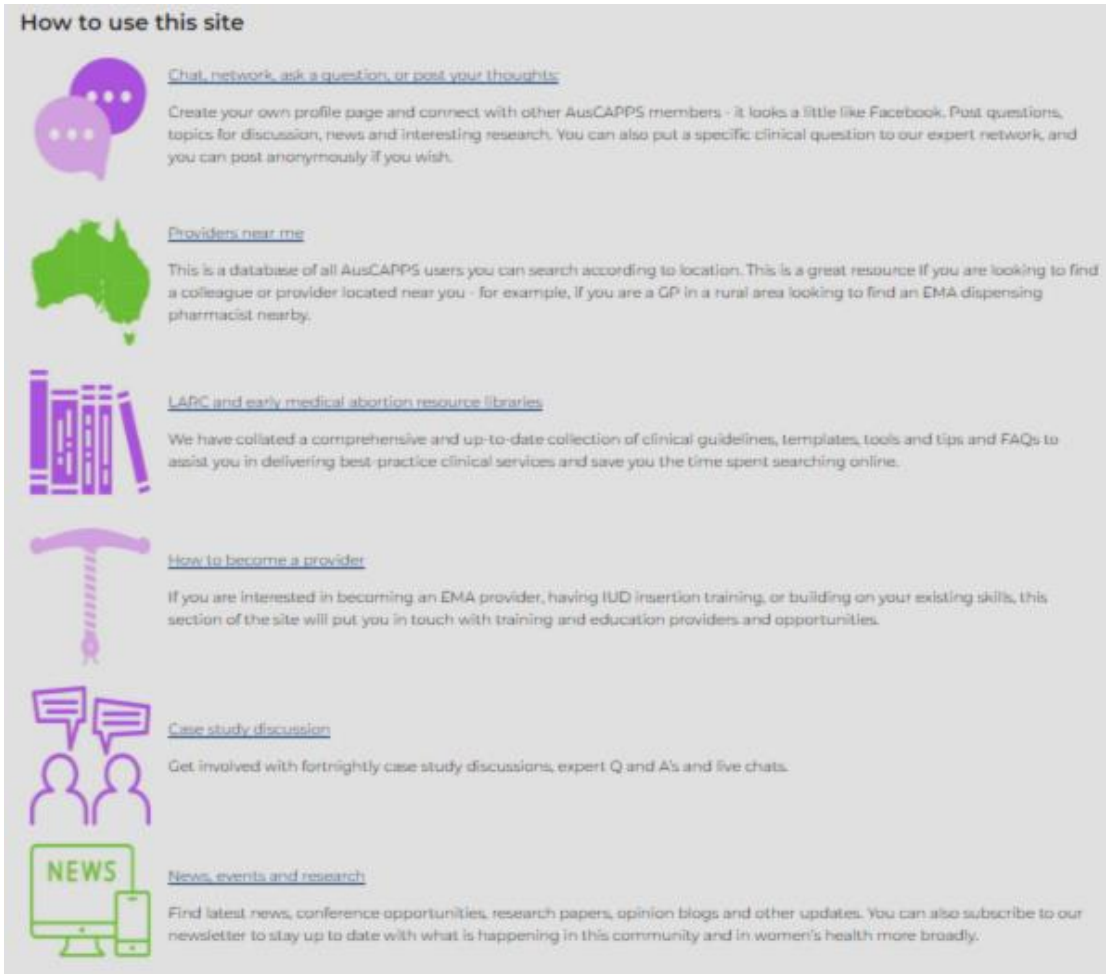
AusCAPPS Network (The Australian Contraception and Abortion Primary Care Practitioner Support Network) is an NHMRC-funded project designed to connect the primary care workforce and increase women's access to contraception and abortion.

IUD and implant use among Australian women remains low, despite being safe and effective for women of all ages.

Early medical abortion is also under-utilised in primary care, despite it being an effective and less-invasive option than surgical termination. These inequities are magnified in rural and regional areas.

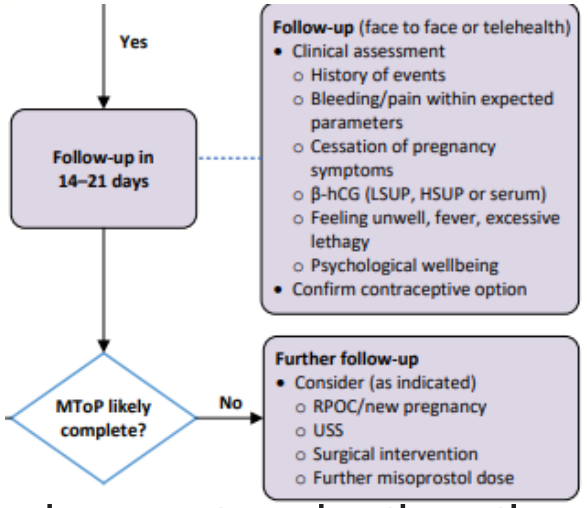
AusCAPPS Network aims to:

- Increase women's access to long acting reversible contraceptive (LARC) methods (IUDs and implants).
- Increase women's access to safe, affordable early medical abortion (EMA), including for women from the most vulnerable populations.



Follow up after ToP

Follow-up is recommended 2-3/52 after termination of pregnancy (ToP).



- Enquire re
  - symptoms suggestive of ongoing pregnancy (failed termination)
  - signs of infection or retained products of conception (RPOC)
  - any abnormal vaginal bleeding or discharge, pain, or fever.
- Note that if a patient starts hormonal contraception immediately after miscarriage or termination, they may experience prolonged abnormal bleeding. However delaying contraception might not be safe!
- If concerns re possible infection, retained products of conception, or abnormal bleeding: - perform examination
  - Temp/BP/Pulse, Uterine tenderness/? Involution, ? Clots at os

  + arrange investigations – swabs incl STI screen, ? βhCG test, ? FBC, ? TVUS
- For medical termination of pregnancy (MToP), consider a 2-to-3-week post-ToP βhCG test to confirm that ToP is complete - **1% = failure rate with MToP**. **4% = Rate of RPOC**
- **Contraception and future pregnancy planning (start at first visit)**
- Ask about patient's feelings about their experience - significant mental health risk

Brisbane South Pathways - Follow Up after ToP

Adverse Events

- Significant Adverse Events should be reported to the TGA
  - Template within clinical software
  - Online at https://aems.tga.gov.au
  - Can also be reported to MS Health via their website

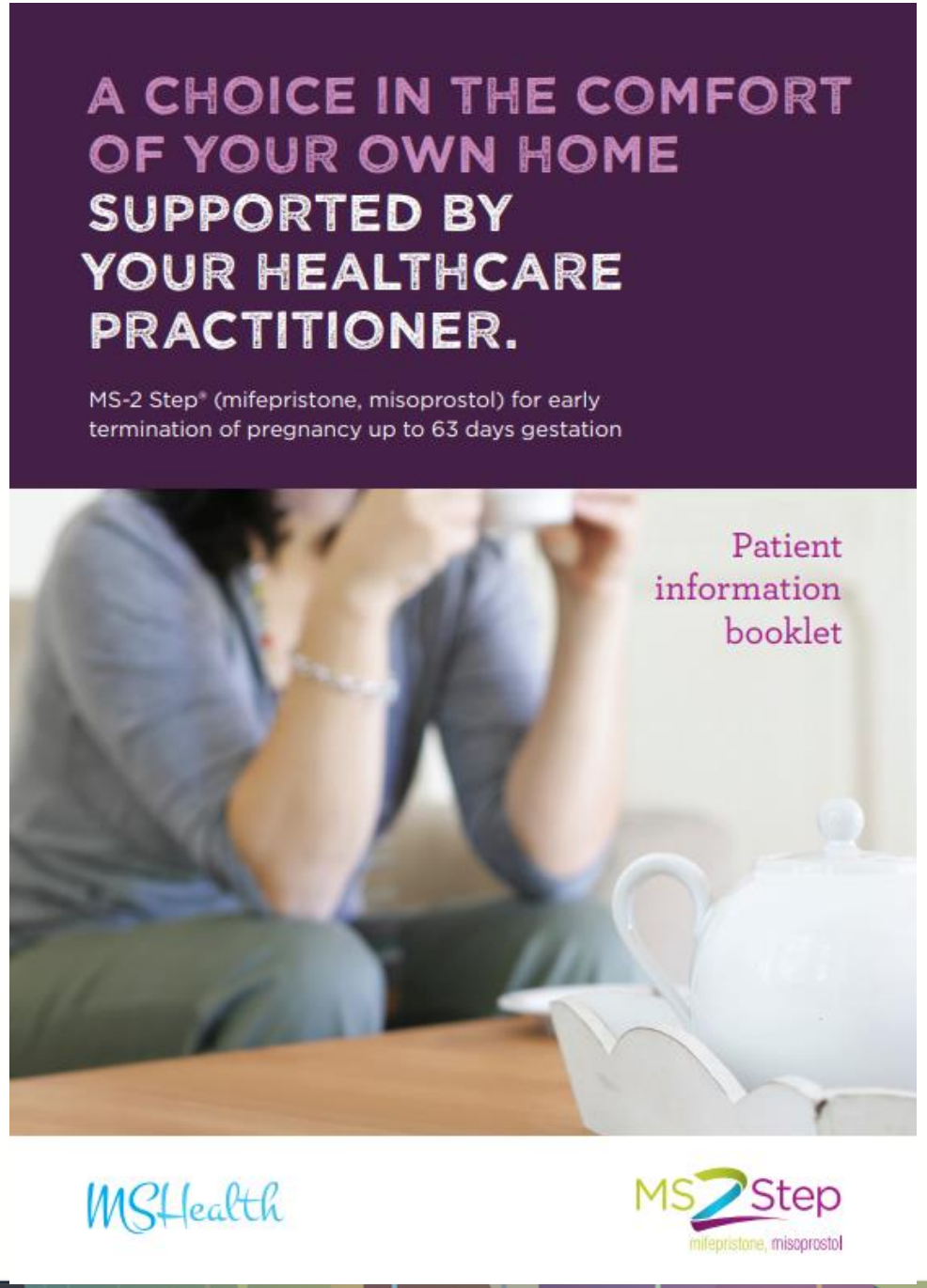
- Admission to hospital for D&C / Hemorrhage

- Reporting SAEs provides accurate real-world data

Costs to patient

- MS 2-Step is a PBS script price approx. $30 / $6 (HCC)
- Without Medicare cost is approx. $350
- Cost of imaging
- Costs of analgesia / anti-emetics/ pads etc
- Time off work

- Consultation item numbers 36/ 44 / 4001
- Reviewing results, focused examination, counselling, medication instructions, further investigations, follow up, safety netting.



Consider ordering [patient information booklets](#) and pre-printed consent forms from [MS Health](#)

[MS-2-Step-Patient-information-booklet.pdf (ms2step.com.au)](#)

Metro South Health

Termination of Pregnancy in MSHHS

Presented by Nicole Price, Acting Nurse Navigator
LBH Early Pregnancy Assessment Unit & MSHHS Pregnancy Choices Unit

We care about you

Queensland Government

Termination of Pregnancy - services available in the region

- MSHHS provides **limited** service to patients within catchment
- Local hospital services prioritise appointments for women with complex healthcare needs or significant social disadvantage - (complex psychosocial concerns, mental health issues, safety issues, behavioural issues, homelessness and/or alcohol/drug issues, low health literacy, lower socio economic, diverse cultural population)
- These patients mostly have no ability to have a termination in private sector where most terminations are performed.
- Statewide Termination of pregnancy clinical guidelines states under the Clinical Standards that:
  - Ideally, offer an assessment appointment within 5 days of referral and provide termination within 2 weeks of the decision to proceed being agreed.
- **Metro South Hospital ToP Nurse Navigator Clinic – now for Logan/Beaudesert and Redland Hospitals**
  - Offering specialised support for women seeking access and information for a termination of pregnancy and patient risk assessment re eligibility
  - Women are offered flexibility in appointment times, +/- phone appointments**.**
  - Written referral (preferably SMART referral) required after contacting Nurse Navigator (preferred via CRH/SMART Referral)
  - Referral information: **Termination of Pregnancy Service**

https://metrosouth.health.qld.gov.au/referrals/gynaecology/termination-of-pregnancy

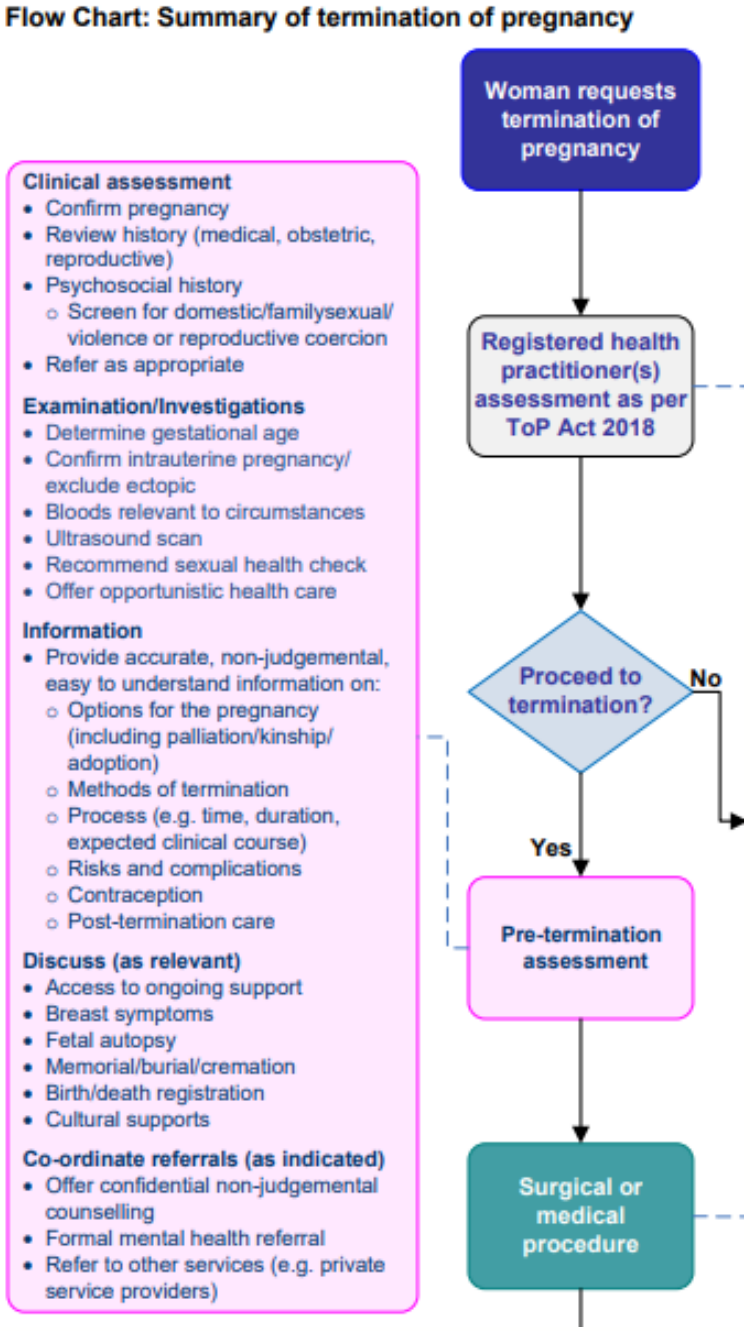
Contact Phone: 0459 462 478 (Mon – Fri 9am to 4pm)

Children by Choice Abortion and Contraception Services MAP -

https://www.childrenbychoice.org.au/information-support/abortion/queensland-abortion-providers/

Further information is available at:

Termination of Pregnancy (ToP) - Community HealthPathways SpotOnHealth (Brisbane South)



Essential referral information

Referrals need to be complete and have all relevant investigations attached as per Termination of Pregnancy Clinical Guidelines https://www.health.qld.gov.au/qcg/publications#top

Incomplete referrals lead to delays - Be Timely!

THIS CAN CHANGE A WOMEN'S OPTION FOR CARE.

- Medical, surgical and obstetric history
- Menstrual history and last menstrual period (LMP) date
- Results of a physical examination as indicated by patient history + vital signs, and BMI
- MUST have confirmation of pregnancy (βhCG) and gestation with **USS proven live intrauterine pregnancy with cardiac activity* & Blood group and anti-bodies**

"Refer Your Patient" - Gynaecology - Termination of Pregnancy

* Ensure sensitive treatment noted on the USS request - if appropriate, ask women re their preference to see/hear USS images (and if had previous LUCS – please request location of placenta on the report)

Assessment

Practice point

Transfer care promptly

Clinicians who are conscientious objectors to TOP care have a professional responsibility and legal requirement to ensure transfer of care within a reasonable time frame.

1. Record the date of the last menstrual period and confirm the pregnancy by urine or blood beta hCG test.
2. If any symptoms of abdominal pain or bleeding, consider an ectopic pregnancy.
3. If the clinician has a conscientious objection to involvement in TOP care there is a professional responsibility and legal requirement to ensure transfer of care within a reasonable time frame. TOP requests are time-critical for both legal requirements and medical reasons.
4. If the patient has a positive pregnancy test and is seeking termination, arrange investigations promptly:
   - Obstetric ultrasound if indicated to site the pregnancy and confirm the gestational age – ensure sensitive treatment from the ultrasonographer

     Ensure sensitive treatment

     Indicate on the ultrasound referral that:

     - the patient may not continue the pregnancy.
     - the ultrasonographer needs to treat the patient with sensitivity.
     - the patient may not wish to view the images.

   - Blood group (to determine if rhesus negative blood group and requirement for anti-D post-termination)
   - Quantitative beta hCG for comparison at follow-up visit after medical termination
   - FBC
   - Chlamydia and gonorrhoea PCR (low vaginal self-swab or urine PCR is appropriate)
   - Other sexually transmitted infection (STI) checks, as indicated
   - Cervical screening, if due
5. Assess the patient's capacity to consent and risk of harm:
   - Patient aged < 18 years

From Draft ToP pages – Health Pathways (Central Queensland – lead for QLD)

true relationships & reproductive health

Brisbane TRUE

Building 1
230 Lutwyche Road
Windsor QLD 4030
PO Box 215
Fortitude Valley QLD 4006
Australia

Phone: 07 3250 0200
Fax: 07 3250 0293

Ipswich
Shop 5/54 Limestone Street
Ipswich QLD 4305
PO Box 429
Ipswich QLD 4305

Phone: 07 3281 4088
Fax: 07 3282 7088
Clinic Hours:
Weekdays
8:00-4:30

True Services across Logan - Education services only
With new clinical services to be expected soon!

Home / ... / Obstetric Requests / Pregnancy Support Counselling

Toggle Alternative Tables for Responsiveness

Pregnancy Support Counselling

When adding services to this page, make sure you check their details to be certain they are not affiliated with Right to Life Australia. There have been instances of organisations deliberately misrepresenting their counselling as non-directional when in fact the intention is to influence patients in line with a particular agenda.

Consider if patient may be eligible for:

- Medicare rebatable counselling.
- Financial assistance.

Request

Children by Choice

Free phone-based counselling and support. Website provides information on pregnancy options, termination of pregnancy access, decision making tools and fact sheets.

- Phone – 1800-177-725
- Hours – Monday to Friday, 9.00 am to 4.30 pm
- Website – www.childrenbychoice.org.au

Marie Stopes Australia

Free phone-based counselling and support.

- Phone – 1300-003-707
- Hours – Monday to Saturday
- Website – www.drmarie.org.au

Pregnancy Counselling Australia

Free confidential 24 hour helpline.

- Phone – 1300-737-732
- Website – www.pregnancycounselling.com.au

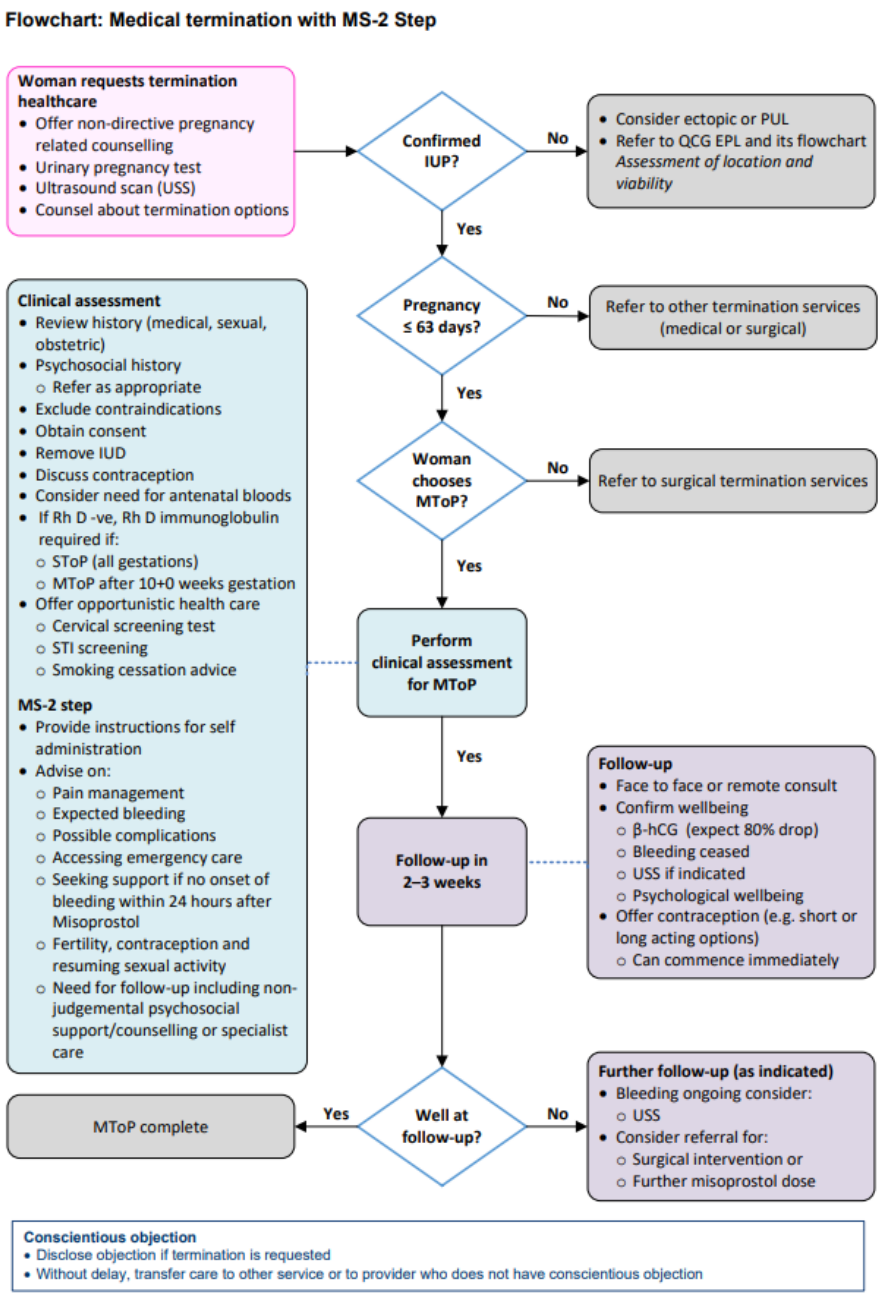
True Relationships and Reproductive Health – Rockhampton

Face-to-face counselling and support.

- Phone – (07) 4927-3999
- Hours – Monday to Friday
- Website – www.true.org.au

Additional referral information:

- If MToP (MS-2-Step) routine antenatal screening not required, but consider based on history & opportunistically with other serum tests
- Quantitative beta hCG for comparison at follow-up visit after medical termination
- For other MToP or SToP, undertake routine AN serum screening (if not already done) FBC, Rubella antibody, Hep B/C serology , HIV serology, Ferritin, and syphilis serology
- HPV vaccination history & CST result if due
- STI screen - endocervical PCR swab for chlamydia + gonorrhoea +/- other STI screen as indicated
- History of smoking/ substance use and alcohol
- History of DFV or sexual violence/reproductive coercion
- Mental Health Status



https://www.health.qld.gov.au/__data/assets/pdf_file/0034/735298/f-top-ms.pdf

QUICK EXIT

Translate this page

Careers | For clinicians | Resources & News

MSI AUSTRALIA

Our services | Client information | Contact | About | BOOK ONLINE | 1300 003 707 | DONATE NOW

Home > Teleabortion services

Abortion by Telehealth

Teleabortion Services

Your Choice, Your Call

Abortion by telehealth (also called teleabortion) is a safe, effective and private way to terminate an early, unplanned pregnancy. This can be done at home, involves two clinical consultations and taking abortion medications.

With abortion by telehealth, you do not need to visit a clinic or pharmacy – we deliver the medicines to you. For most people, an ultrasound from the nearest imaging service is all that you need to proceed.

MSI is the most experienced provider of abortion by telehealth in Australia. Our team of doctors, nurses and support services are experts in abortion care, and are committed to providing non-judgemental healthcare.

For more information about abortion by telehealth, please watch our short video.

Book Now

MSI has led the way in abortion care in Australia, including abortion by telehealth, and we have the highest possible standards of care and service.

It can be hard to know how best to support someone who has had an abortion. We provide this guide for anyone who wants to learn more about timely and empathic support.

https://www.msiaustralia.org.au/abortion-by-telehealth-services/

What are my costs for abortion by telehealth?

Abortion by telehealth is the lowest cost way to access abortion care.

People with Medicare Card	People with Health Care Card	People without Medicare
Your cost is $248.70* plus $71.60 for medications & delivery	**Your cost is $248.70**** plus $47.70 for medications & delivery	**Your cost is $410.73***** plus $394.27 for medications & delivery

* $100 is payable before your first clinical consultation. A second payment of $380.50 is payable before your second clinical consultation. You are eligible for total Medicare rebates of $160.20 which we can process for you.

** $100 is payable before your first clinical consultation. A second payment of $356.60 is payable before your second clinical consultation. You are eligible for total Medicare rebates of $160.20 which we can process for you.

*** $100 is payable before your first clinical consultation. A second payment of $705 is payable before your second clinical consultation. People with private health insurance may be able to claim a benefit.

There are no hidden costs.

This price includes:

- Two clinical consultations
- Abortion medicines delivered to your home
- Pain and nausea medicines
- A special urine pregnancy test to use 14–21 days after you've taken the abortion medicines
- Access to specialised support services

Comparison of abortion services at MSI Australia

For a detailed comparison of the different methods of abortion care, read Understanding your options: surgical abortion vs medical abortion.

Abortion by telehealth	Medical abortion in clinic	Surgical abortion
• Up to 9 weeks gestation	• Up to 9 weeks gestation	• Up to 20 weeks gestation in some states
• No referral required	• No referral required (except WA)	• No referral required (except WA)
• Ultrasound through local imaging provider	• Ultrasound in clinic	• Ultrasound in clinic
• Phone/video clinical consultations	• In person clinical consultations and support	• In person clinical consultations and support
• Medications delivered to your home	• Medications provided in clinic	• In a licensed day surgery
• Support person recommended for Day 2	• Support person recommended for Day 2	• Sedation or local anaesthetic
• Less than 4% incomplete abortion risk	• Less than 4% incomplete abortion risk	• Support person required for pick-up
• Medium to heavy bleeding	• Medium to heavy bleeding	• Less than 2% incomplete abortion risk
• Variable pain	• Variable pain	• Light bleeding
• Self-managed follow up	• Self-managed follow up	• Follow-up not usually required
	Learn more about in-clinic medical abortion	Learn more about surgical abortion

What kind of abortion can I have?

There are gestation limits on which kind of abortion you can have in Australia. To check which abortion methods are available to you, use our gestation calculator by entering the first date of your last period. This will provide you with a gestation estimate in weeks and days, which will later need to be confirmed by an ultrasound.

Please enter the date of the First Day of your last normal menstrual period to estimate your gestation. *

DD | MM | YYYY

Estimate your gestation

Queensland Virtual Early Medical Termination of Pregnancy Service (QVEMToPS) is coming!

QVEMToPS are pleased to partner with Sunshine Coast Hospital and Health service to deliver the service statewide.

Clinical Advisory Group being established to co-design the QVEMToPS Model of Care, including but not limited to:

- Service eligibility criteria
- Referral pathways into the service
- Referral pathways to alternative services where QVEMToPS is not clinically appropriate
- Local escalation pathways
- Outcome measures

Resources available in MSH region

- 13 HEALTH – 13 43 25 84 provides health information, referral and services to the public
- Children by Choice – 1800 177 725 offers free all-options pregnancy counselling, information and referrals Qld wide
- Red Nose Grief and Loss/SANDS - 1300 308 307 – 24/24 support line
- Provide support to grieving individuals and families.
- For patients who may have made decision for ToP due to fetal abnormalities or other health concerns
- Women's Health Qld – 1800 017 676 offers health promotion, information and education services for women and health professionals
- True Relationships and Reproductive Health provides expert reproduction and sexual healthcare
- Termination of Pregnancy Clinical Guidelines https://www.health.qld.gov.au/qcg/publications#top – provides patient information + Flowcharts/ Education for Health Professionals
- Clinical Excellence Queensland information for health practitioners and services: Termination of Pregnancy
- Termination of pregnancy in Queensland information for Health Practitioners - https://clinicalexcellence.qld.gov.au/sites/default/files/docs/priority-area/termination-pregnancy/termination-pregnancy-practitioner.pdf
- Key facts about the Termination of Pregnancy Act https://clinicalexcellence.qld.gov.au/sites/default/files/docs/priority-area/termination-pregnancy/termination-pregnancy-act-facts.PDF

World Contraception Day 26th September 2024

Non-users of long-acting reversible contraception (LARC) were **20 times more likely** to experience an unintended pregnancy when compared to LARC users[1]

Here's some important context and statistics related to the day:

40% of pregnancies worldwide are unplanned[2]

25% of Australian women experience an unintended pregnancy; **40% of those** pregnancies were reported as a first pregnancy (18-32yo)[3*]

*A cross-sectional, population-based, national survey of women and men aged 18-51 years recruited from a random sample of electors on the Australian Electoral Roll in 2013. Data from 2,235 completed questionnaires were analysed.

Abortion numbers in Australia are estimated to be **80,000 every year**[4]

Significant numbers of ToPs in MSHHS catchment, and many are late (≥ 22 weeks').
More widespread promotion of LARCs could prevent this – let's make a real difference to improve the lives of women and girls in this area.

Green Group – Task 1

- 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

Metro South Health

Quality healthcare every day

Follow Up Abnormal Cervical Screening Test

Dr Sanja Savic
Senior Staff Specialist - Obstetrics and Gynaecology
Logan Hospital

ICARE² values

INTEGRITY COMPASSION ACCOUNTABILITY RESPECT ENGAGEMENT EXCELLENCE

Queensland Government

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.

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)

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, 15 of which classified ‘high risk’ or oncogenic.
- Most HPV infections are cleared within 12-24/12; up to 10% persist
- 98% of people infected with genital HPV will clear the virus naturally within 5 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

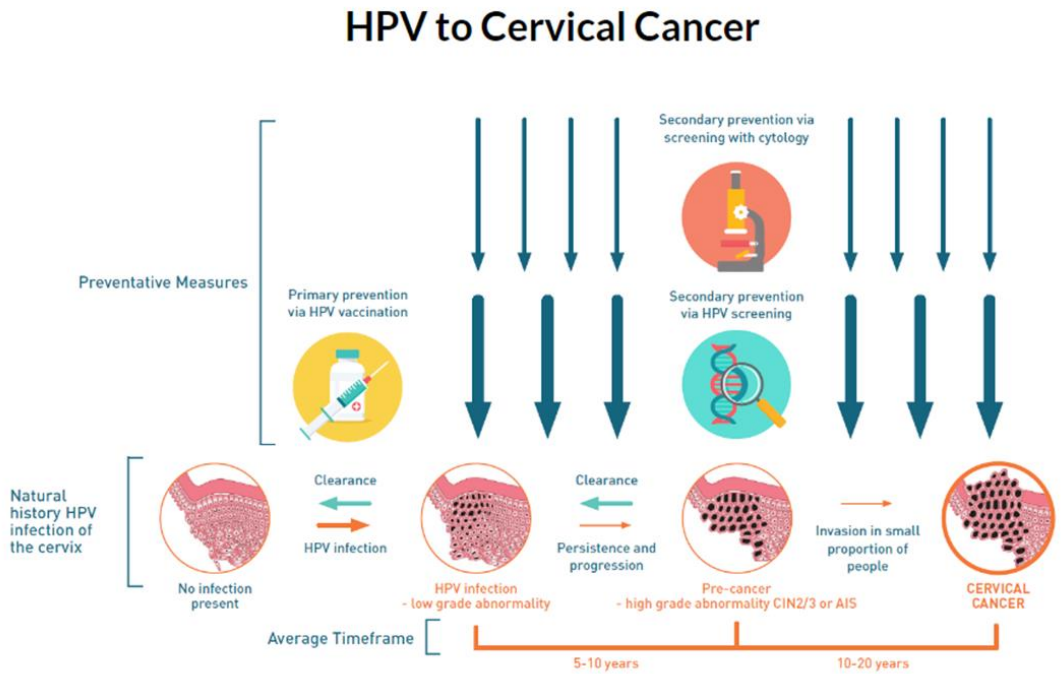


Image from: VCS Pathology, National Cervical Screening Program Guidelines, HPV and Cervical Screening. Available from: https://acpcc.org.au/wp-content/uploads/2024/05/24016_VCS.HPV-AND-CERVICAL-SCREENING.CD04.pdf

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

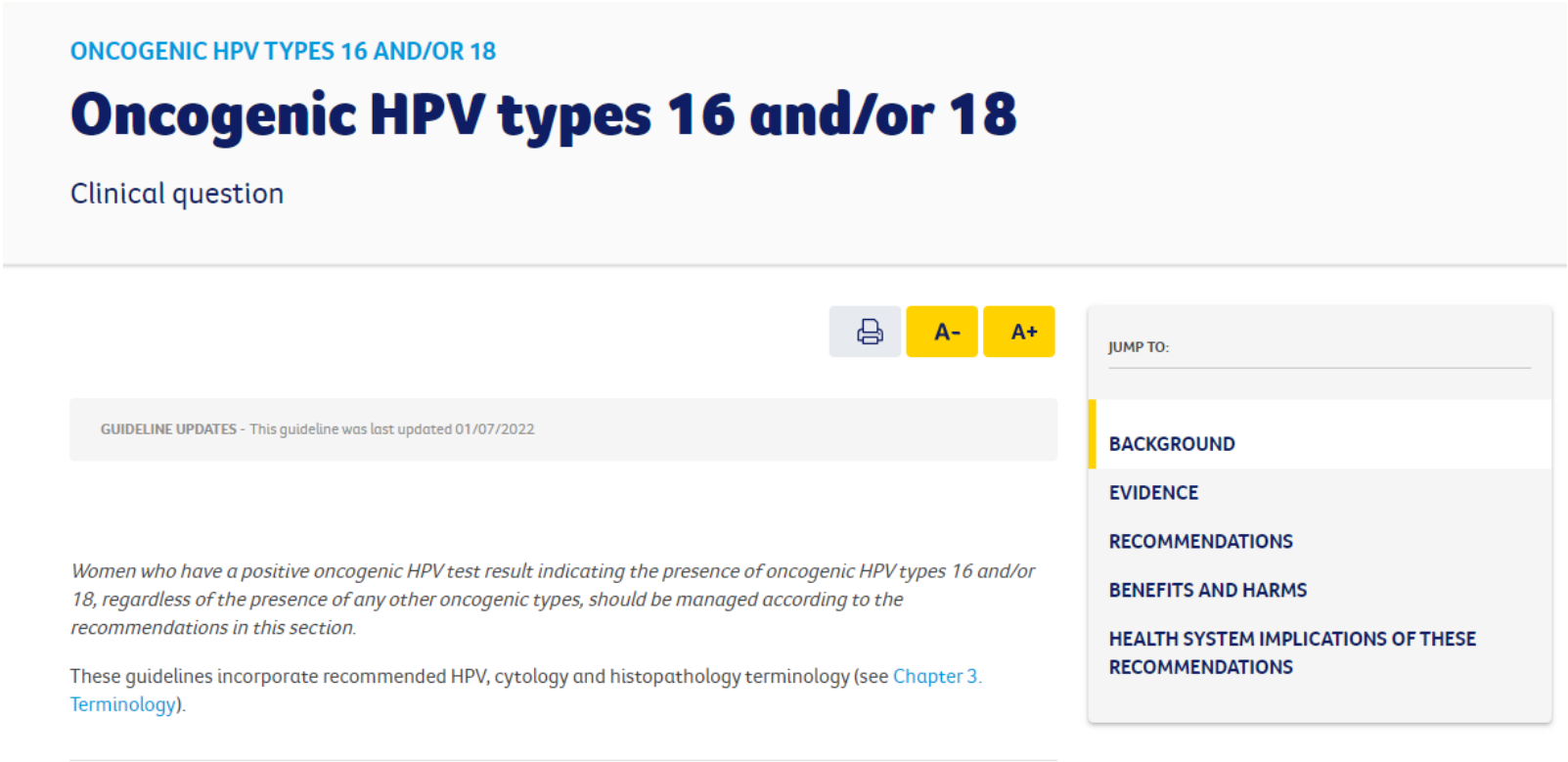
National Strategy for the Elimination of Cervical Cancer

- 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 the next century (2018 in Australia – 6.5 new cases /100, 000 women)
- 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



- 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

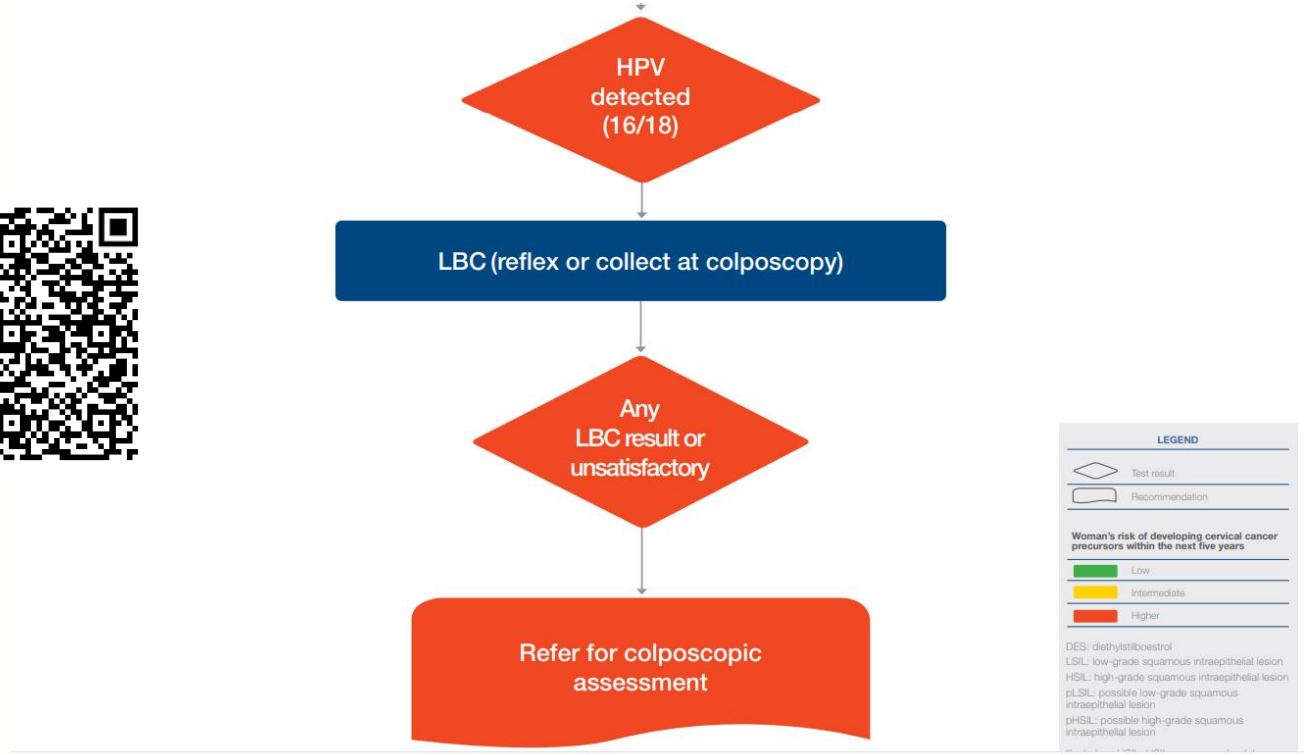
GUIDELINE UPDATES - This guideline was last updated 01/07/2022

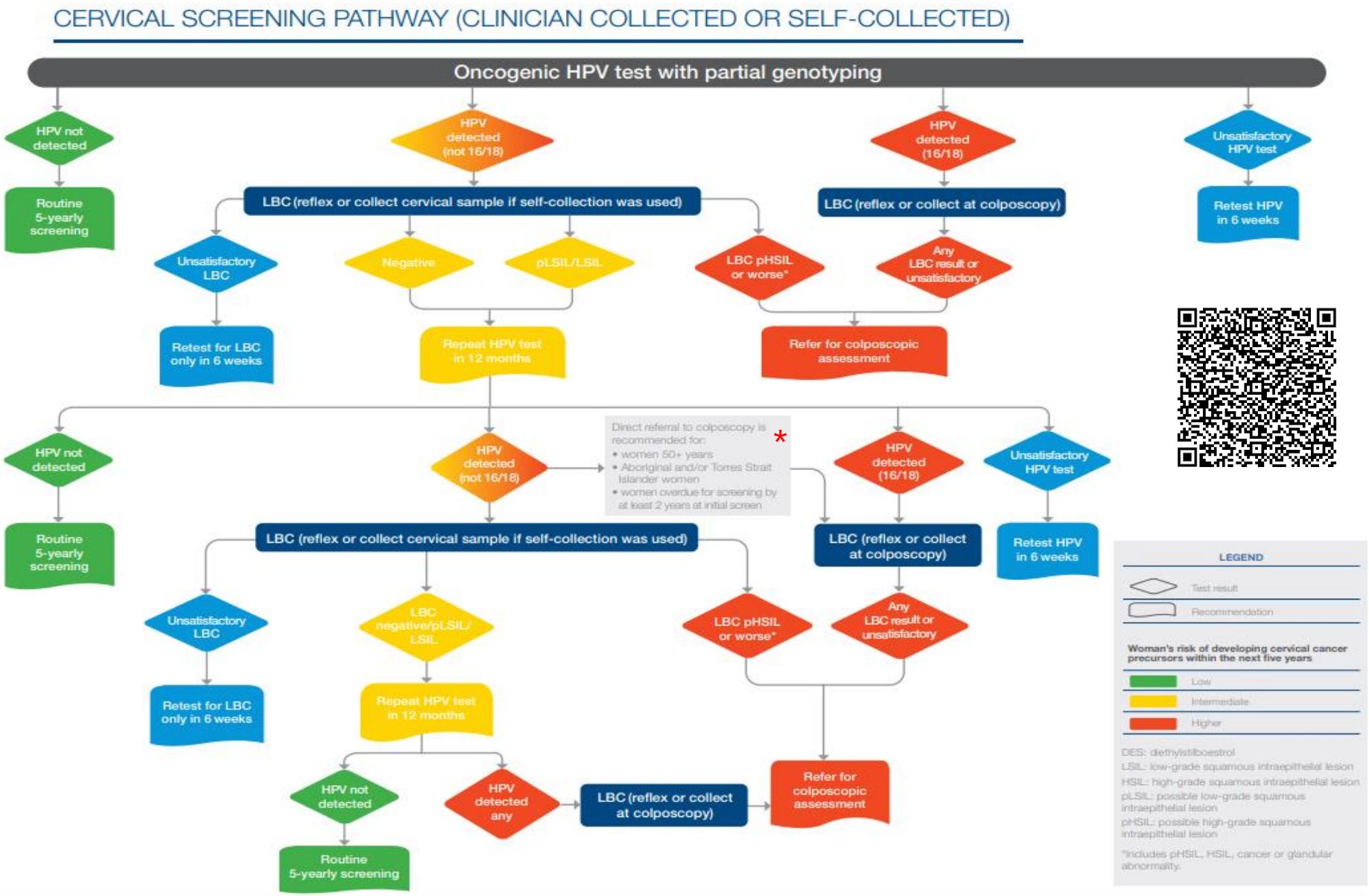
CLINICAL GUIDELINES SITEMAP

Links to Management of oncogenic HPV test results flowcharts:

- Flowchart 6.1 Cervical screening pathway for primary oncogenic HPV screening (HPV tests on clinician-collected or self-collected samples)
- Flowchart 6.2 Cervical screening pathway for primary oncogenic HPV testing (HPV not detected)
- Flowchart 6.3. Cervical screening pathway for primary oncogenic HPV screening (HPV tests on clinician-collected or self-collected samples): HPV16/18 detected
- 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

https://www.cancer.org.au/clinical-guidelines/cervical-cancer/cervical-cancer-screening/management-of-oncogenic-hpv-test-results/flowcharts





Patients with positive non-16/18 but normal or LSIL on LBC
DO NOT need referral unless persistent on 2 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

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

* EXCEPTIONS:

- non 16/18 in patient 70-74yrs – for immediate colposcopy
- after 2 non16/18 HPV positive tests refer for colposcopy if –
  - Aged 50yrs+
  - Aboriginal and/or Torres Strait Islander
  - Overdue by at least 2 years on initial screen

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.
- 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)

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)

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.

CST/HPV self-collections

Eligible patients

- 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

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 five reasons, including patients:
  - with symptoms suggestive of cervical cancer e.g., unexplained bleeding, unexplained persistent discharge
  - who are undergoing “test of cure” after treatment for high-grade squamous intraepithelial lesion (HSIL)
  - who have been treated for a glandular abnormality, including adenocarcinoma in situ (AIS)
  - who have been exposed to diethylstilboestrol (DES) in utero
  - who have had a total hysterectomy with a history of HSIL.

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.

.

- **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!**

Likelihood of an HPV (non 16/18) result, requiring a second appointment, is ~6% for routine CSTs. However, this is **highly age dependent.**

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%		

- 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

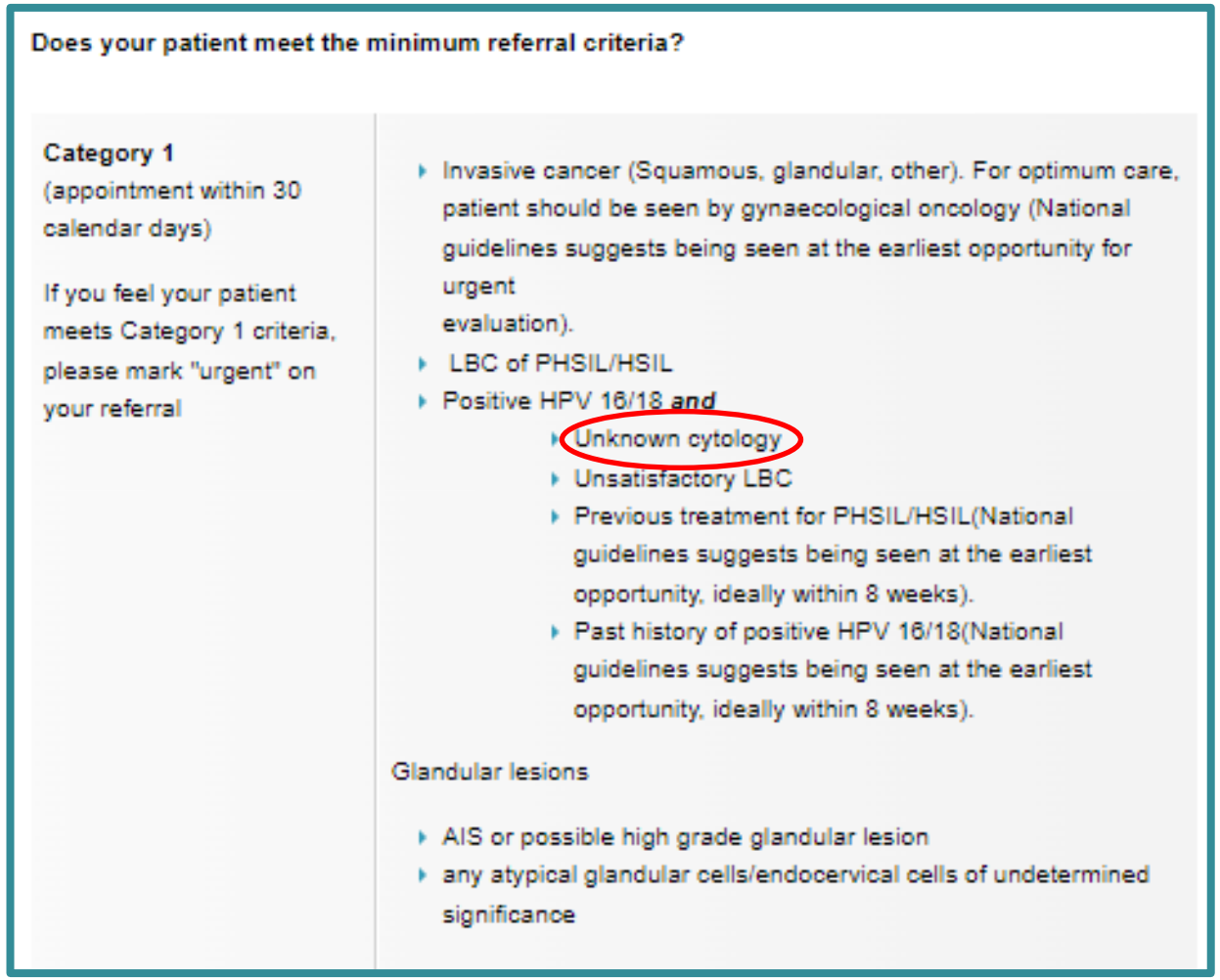
- Patients with positive non-16/18 but normal or LSIL on LBC **DO NOT** need referral but a repeat CST at 12/12 If remains positive non-16/18 but normal or LSIL on LBC, REPEAT again in 12 months (only refer if HPV non-16/18 positive on 3 consecutive tests (or clinical concerns)
- Women who have been treated for HSIL (CIN2/3) do not need a post-treatment colposcopy. These women should have a co-test (HPV and LBC 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

REFER YOUR PATIENT – METRO SOUTH HHS

Abnormal cervical screening / cervical dysplasia / abnormal cervix



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 ***and***
  - 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

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.

Cervical Cancer Screening - Community HealthPathways Brisbane South (SpotOnHealth)

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
	  ▸ on 3 consecutive yearly tests **OR**
	  ▸ in a person who is:
	  ▸ two or more years overdue for screening at the time of the initial screen
	  ▸ identifies as Aboriginal or Torres Strait islander
	  ▸ aged 50-69 years
	  ▸ women aged 70+
	  ▸ immune deficient women
	  ▸ women currently undergoing Test of Cure following treatment of histological HSIL
	▸ HPV other
	▸ 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 – 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
	▸ Any abnormal result and past history of excisional treatment of AIS

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)

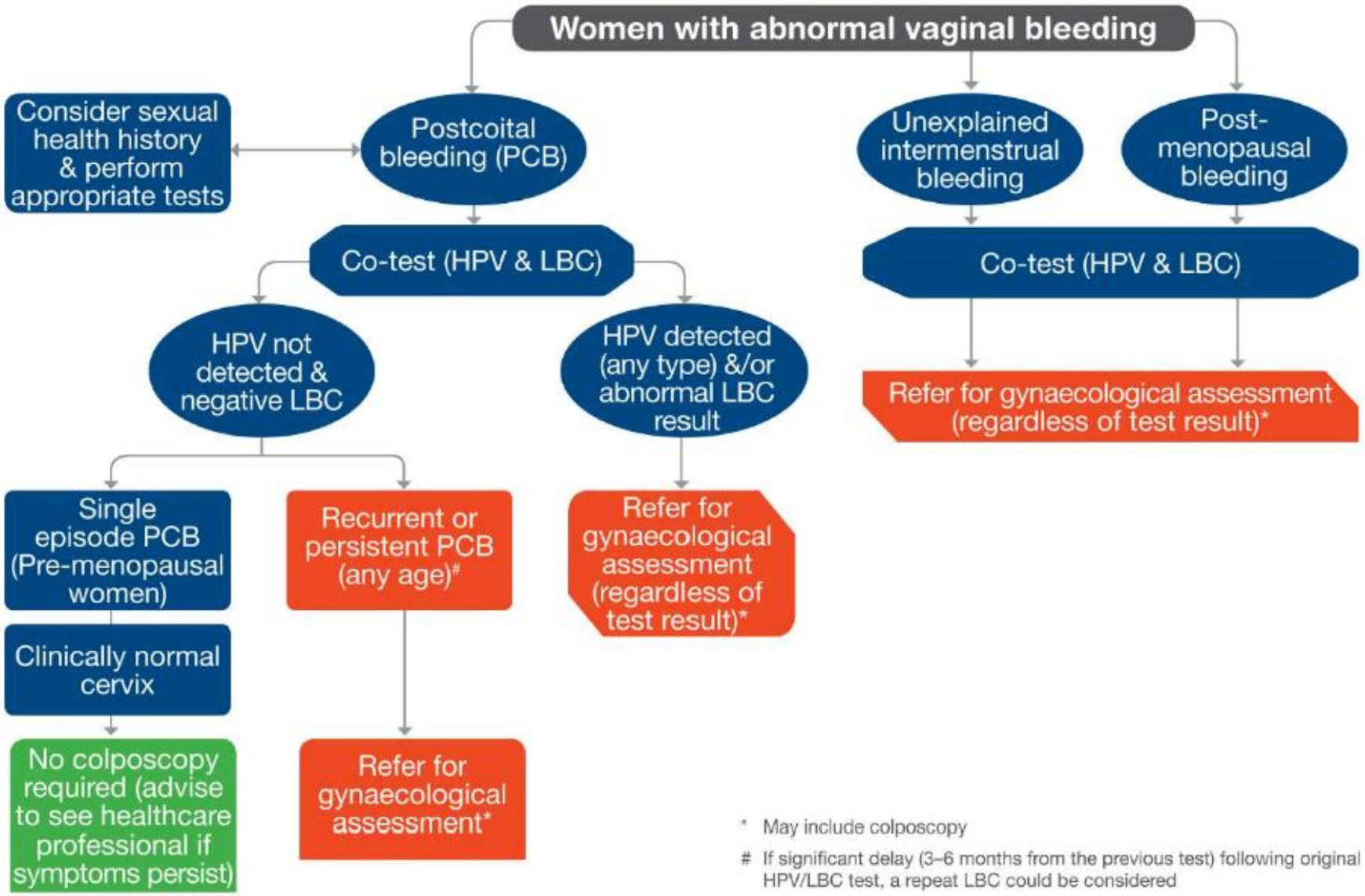
If a specific test result is unable to be obtained due to access, financial, religious, cultural or consent reasons a Clinical Override may be requested. This reason must be clearly articulated in the body of the referral.

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

- BMI
- HPV Vaccination history
- STI screen result, endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA
- History of smoking

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

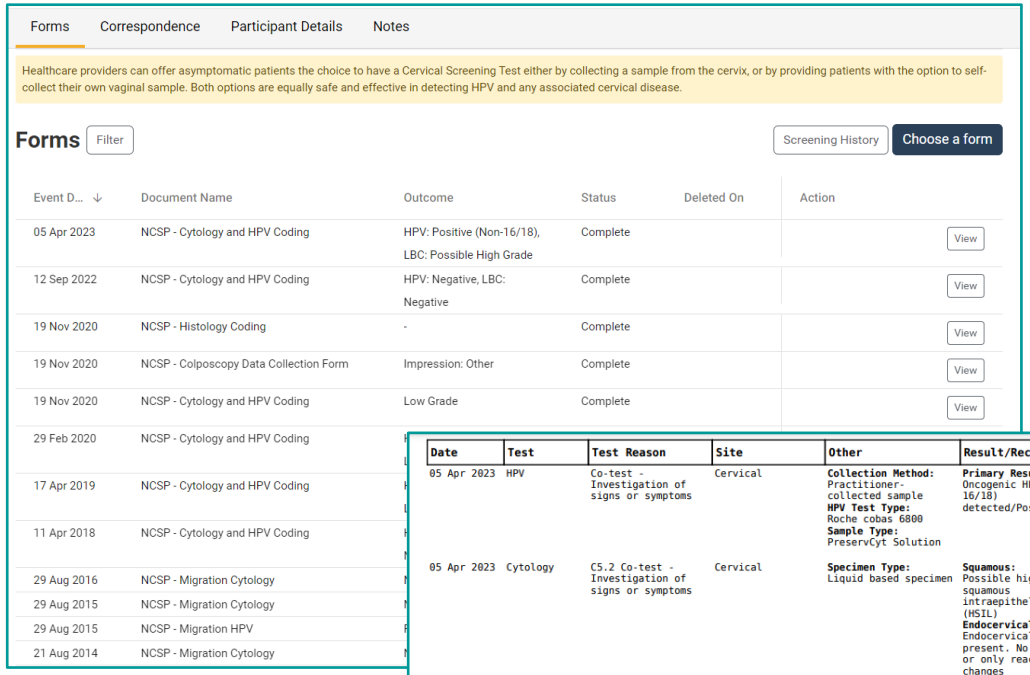
INVESTIGATION OF WOMEN WITH ABNORMAL VAGINAL BLEEDING



* 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



Forms | Correspondence | Participant Details | Notes

Healthcare providers can offer asymptomatic patients the choice to have a Cervical Screening Test either by collecting a sample from the cervix, or by providing patients with the option to self-collect their own vaginal sample. Both options are equally safe and effective in detecting HPV and any associated cervical disease.

Forms Filter — Screening History — Choose a form

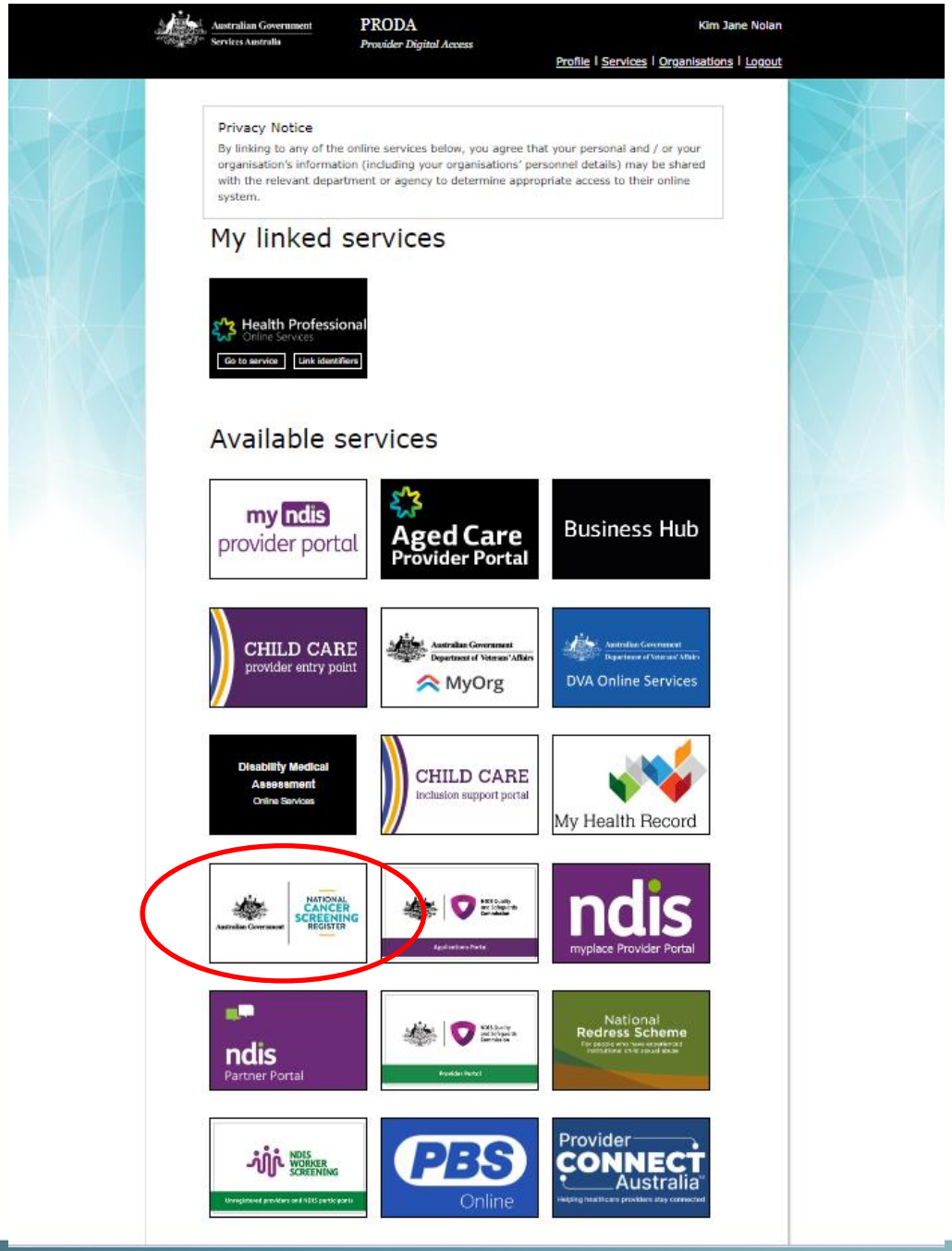
Event D...	Document Name	Outcome	Status	Deleted On	Action
05 Apr 2023	NCSP - Cytology and HPV Coding	HPV: Positive (Non-16/18), LBC: Possible High Grade	Complete		View
12 Sep 2022	NCSP - Cytology and HPV Coding	HPV: Negative, LBC: Negative	Complete		View
19 Nov 2020	NCSP - Histology Coding	-	Complete		View
19 Nov 2020	NCSP - Colposcopy Data Collection Form	Impression: Other	Complete		View
19 Nov 2020	NCSP - Cytology and HPV Coding	Low Grade	Complete		View
29 Feb 2020	NCSP - Cytology and HPV Coding				
17 Apr 2019	NCSP - Cytology and HPV Coding				
11 Apr 2018	NCSP - Cytology and HPV Coding				
29 Aug 2016	NCSP - Migration Cytology				
29 Aug 2015	NCSP - Migration Cytology				
29 Aug 2015	NCSP - Migration HPV				
21 Aug 2014	NCSP - Migration Cytology				

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.

Page 1 of 6

Sender: NCSR 1800 627 701



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)

Cervical Screening, HPV and Self Collection: Clinical Education Course

- developed by VCS Pathology, a division of the Australian Centre for the Prevention of Cervical Cancer (ACPCC), to provide Australian Primary Healthcare Practitioners with the knowledge and skills to be able to offer the option of HPV self-collection to eligible patients and increase cervical screening participation rates. (RACGP Activity ID: 564285)

12 CPD Hours

Educational Activities	4 CPD Hours
Reviewing Performance	3 CPD Hours
Measuring Outcomes	5 CPD Hours

Thu 14th Sep 2023 - Tue 31st Dec 2024

VIC

e-Learning

Australian Centre for the Prevention of Cervical Cancer

This program has been developed by VCS Pathology, a division of the Australian Centre for the Prevention of Cervical Cancer (ACPCC), to provide primary Healthcare Practitioners across Australia with the knowledge and skills to be able to offer the option of HPV self-collection to eligible patients and increase cervical screening participation rates.

VCS Pathology

Australian Centre for the Prevention of Cervical Cancer

CLICK HERE to get started, or click on one of the sections below.

How and when will my CPD hours be allocated?

If you have completed the entire program, CPD hours and a Certificate of Completion will be provided by ACPCC **within 3-4 weeks**. If you complete the program before the end of December, your CPD hours will be attributed to that calendar year.

Introduction

Module 1
HPV Self-Collection Introduction

Module 2
Science of Cervical Screening and the Evidence for Self-Collection

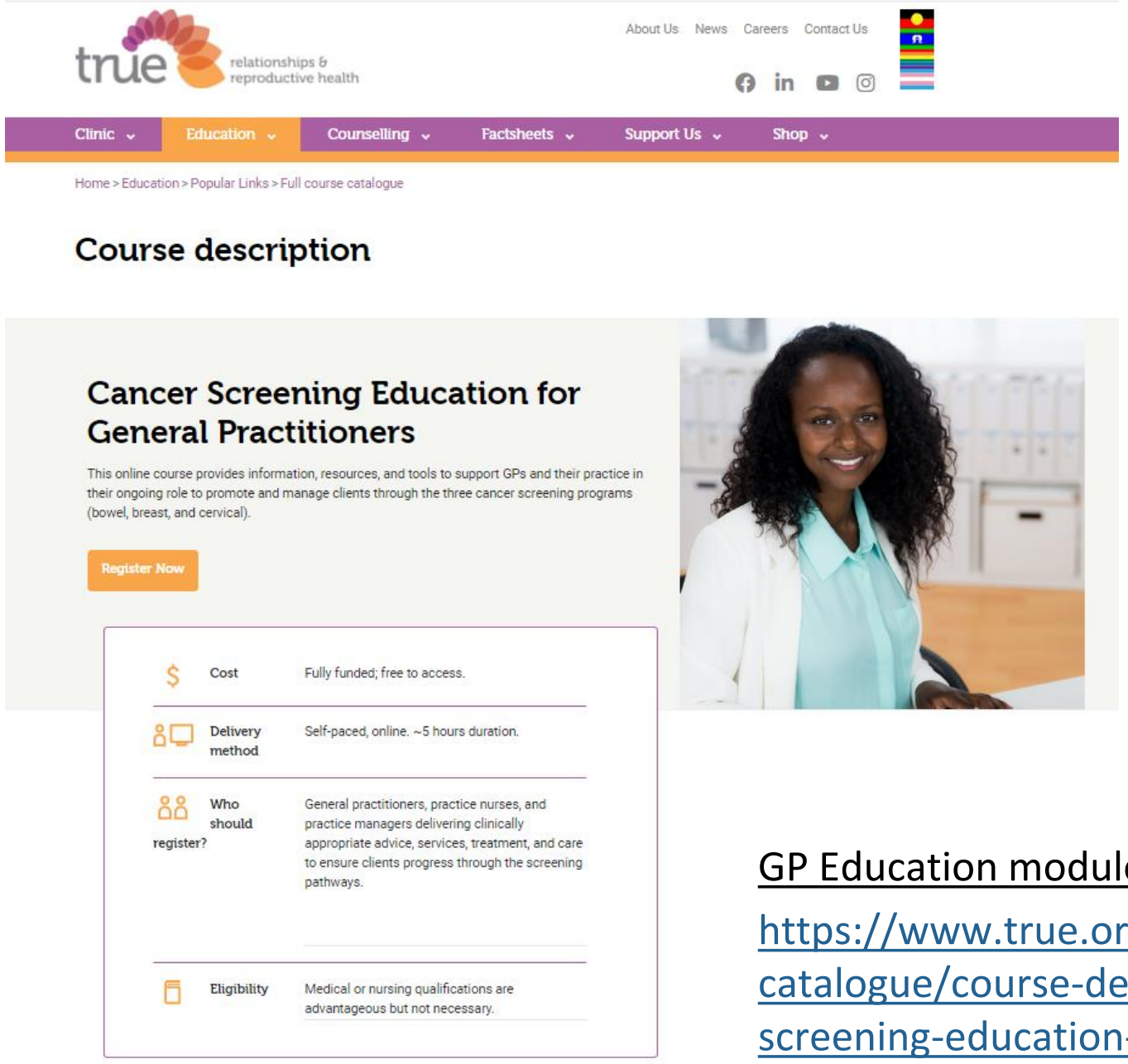
Module 3
National Cervical Screening Program Self-Collection Policy

Module 4
HPV Self-Collection in Clinical Practice

Module 5
Underscreened Groups and Using Your Practice Systems to Reach Them

Reflection

Evaluation



The education package consists of:

- Introduction to Australia's Cancer Screening Programs
- 10 self-paced, online modules
  - Population based cancer screening
  - General practitioners and BreastScreen Queensland
  - Assessing breast cancer risk
  - General practitioners and the National Cervical Screening Program
  - Symptoms and signs of cervical cancer
  - When to use a co-test
  - Self-collection in cervical screening
  - Human papillomavirus (HPV) and the HPV vaccine
  - General practitioners and the National Bowel Cancer Screening Program
  - Assessing bowel cancer risk
- 1 webinar
  - Cervical cancer and symptoms
- 2 podcasts
  - Bowel screening
  - Breast screening
- Resources

Course Info

Course outcomes

CPD information

RACGP CPD 3 00 2

This education is a CPD Accredited Activity under the RACGP CPD Program.

true relationships & reproductive health

GP Education module online – FREE

https://www.true.org.au/education/popular-links/full-course-catalogue/course-description/?eventtemplate=27-cancer-screening-education-for-general-practitioners

Pink Group – Task 1

- Marlene is 46 yo Aboriginal woman G4P4 - all SVD
- BMI 35kg/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

Metro South Health

Quality healthcare every day

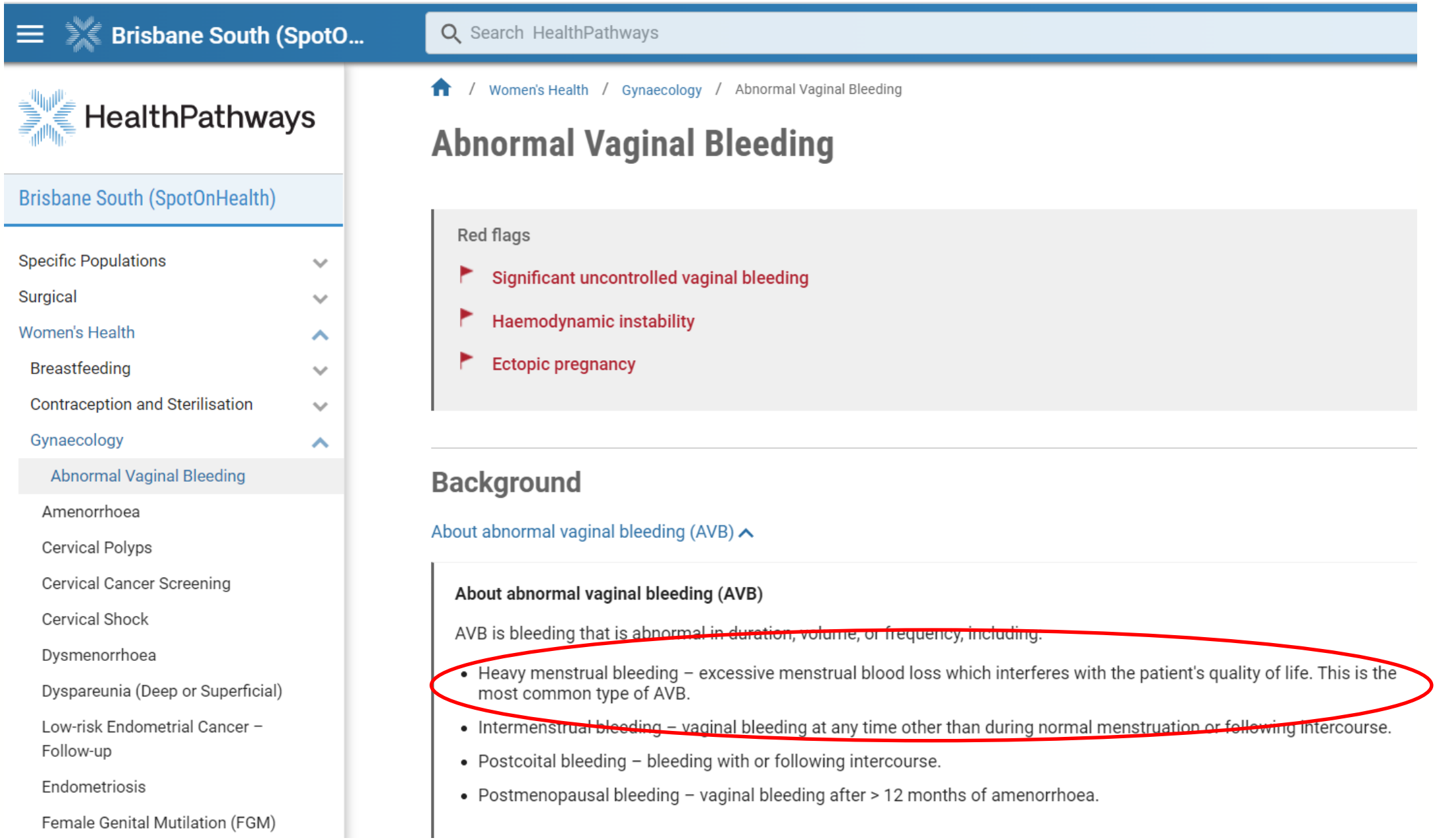
Heavy Menstrual Bleeding

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

ICARE² values

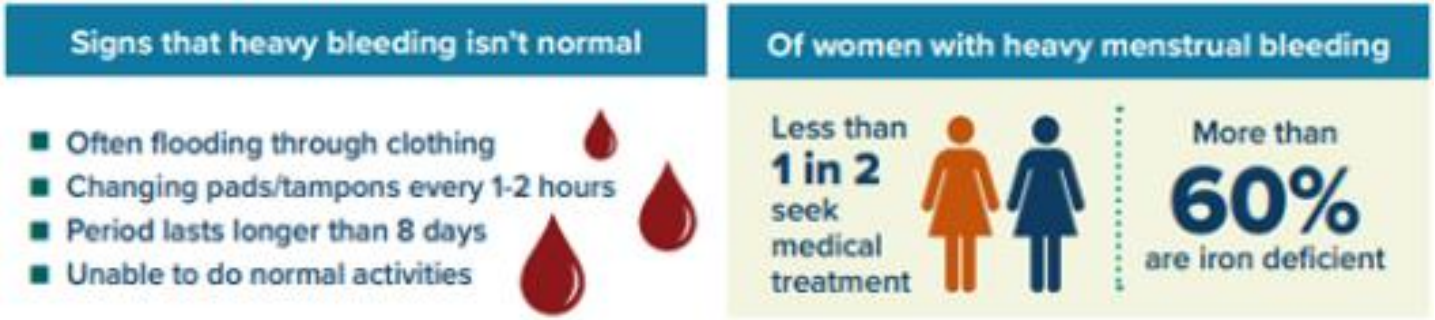
INTEGRITY COMPASSION ACCOUNTABILITY RESPECT ENGAGEMENT EXCELLENCE

Queensland Government



https://brisbanesouth.communityhealthpathways.org/15976.htm

Assessment:



- Hx and nature of bleeding (menstrual history)
- ? Associated dysmenorrhoea, dyspareunia, discharge/itch/dryness
- Impact on quality of life
- Comorbidity especially presence of anaemia, STI risk
- Consider systemic causes e.g., hypothyroidism, PCOS, bleeding disorders
- Symptoms suggestive of structural or histological abnormality (including intermenstrual and postcoital bleeding)
- 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 up to 1/2 do not seek medical care worldwide.

Peak incidences – adolescence and in 5th decade of life

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

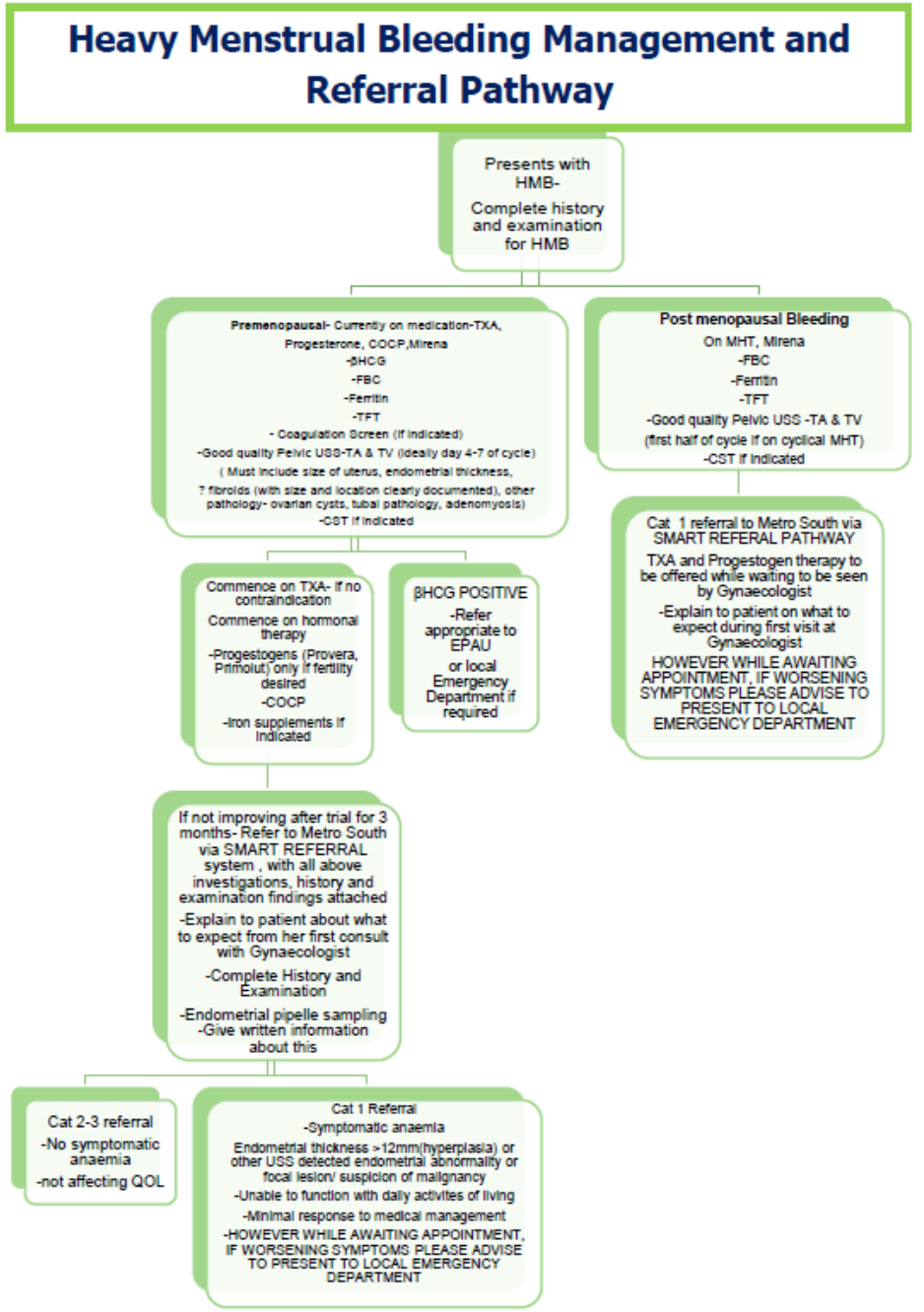
Examine the patient:

- Measure vital signs – temperature, pulse, blood pressure.
- Check for signs of anaemia - skin and conjunctival pallor.
- Perform abdominal and pelvic examination, unless the patient has never had vaginal intercourse. Consider a chaperone.

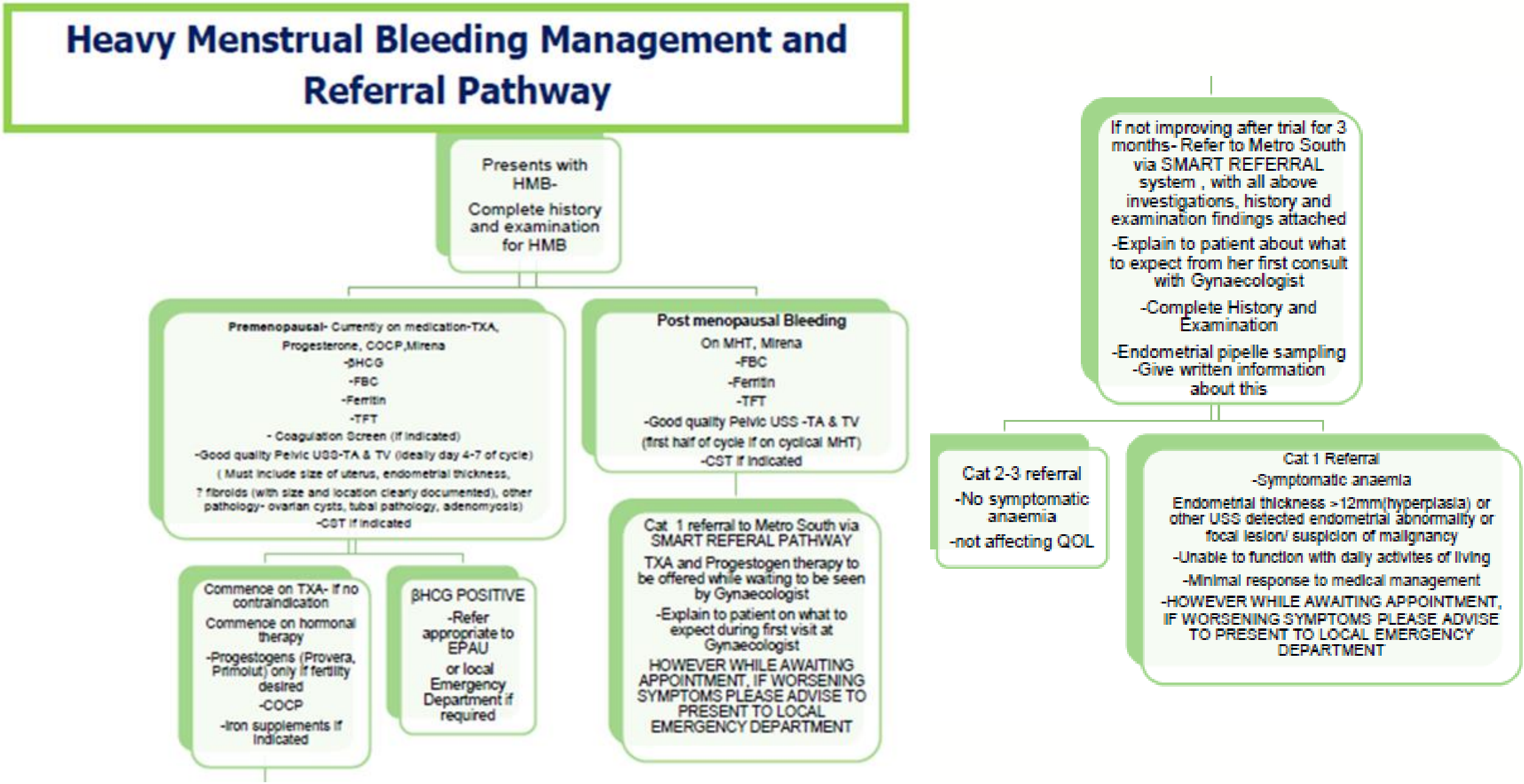
Investigations:

- Cervical co-test (HPV + LBC)
- FBC, iron studies/ferritin, TSH
- Consider βHCG, Coagulation profile, FSH, STI testing
- Pelvic/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?

MSH Heavy Menstrual Bleeding Management and Referral Pathway



Heavy Menstrual Bleeding Management and Referral Pathway



Treatment Options:

Pharmacological Rx –

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

Surgical Rx -

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

Anovulatory Bleeding:

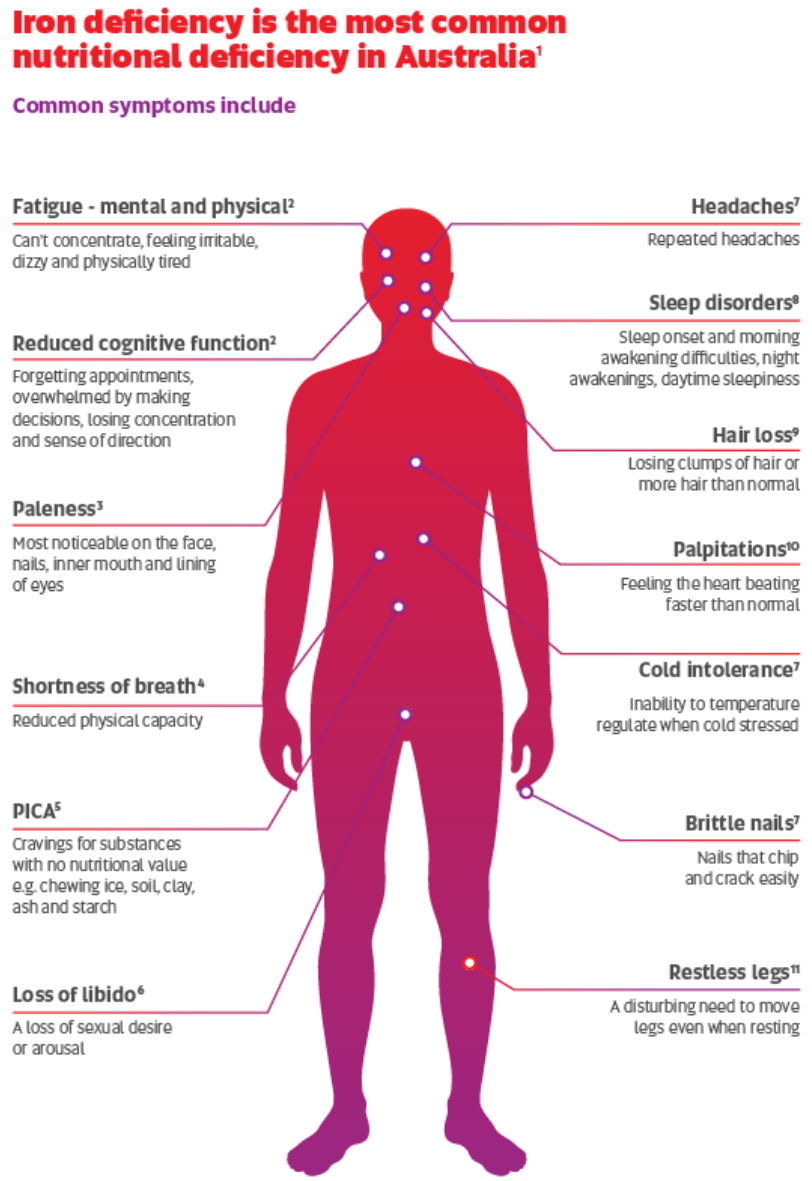
Suspect if:

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

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

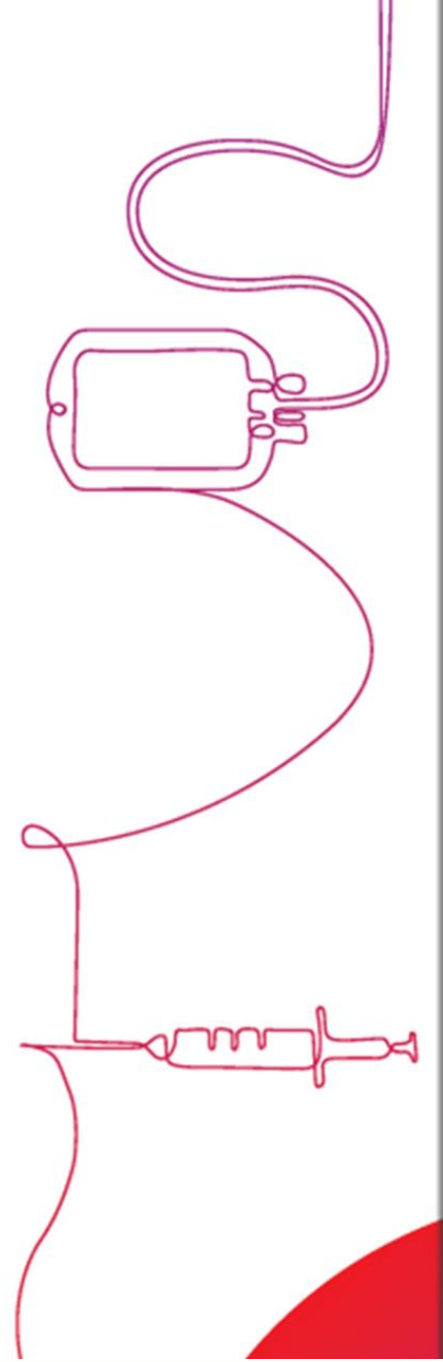
See the relevant pathway for details – Intravenous Iron Infusion

Browns Plains
Calamvale
Carindale
Cleveland
Daisy Hill
Forest Lake
Greenslopes
Gumdale
Highgate Hill
Jimboomba
Jindalee
Kangaroo Point
Logan Central
Logan Village
Loganholme
Morningside
Rochedale
Sherwood
Sinnamon Park
Sunnybank Hills
Tingalpa
Underwood
Upper Mount Gravatt
Victoria Point
Wellington Point
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

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 mg (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)

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., polycystic ovarian syndrome(PCOS)
- 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)

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
- associated post-coital (or intermenstrual) bleeding and concerns re appearance of cervix, vagina or vulva
- cervical polyp

Ongoing management of menorrhagia – medical

If normal investigations and no risk factors for malignancy, 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
2. NSAIDs e.g., mefenamic acid, ibuprofen or naproxen:
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
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

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 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, particularly if contraception is not needed, as helps to counter unopposed estrogen, ? prevents retrograde menstruation and development of endometriosis.

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

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**

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**

Morning Tea

Session 2

Time	Session name	Presenter	Delivery
11.00 am	Case Discussion – Menopause Management	Group Spokesperson Dr Prem Gill	Facilitated groups Power Point Presentation & Forum Discussion
11:40 am	Case Discussion – Pelvic Floor Prolapse	Group Spokesperson Dr YuHwee Tan	Facilitated groups Power Point Presentation & Forum Discussion
12:10 pm	Case Discussion – Incontinence	Group Spokesperson Dr YuHwee Tan	Facilitated groups Power Point Presentation & Forum Discussion
12:40 pm	Case Discussion – Pelvic Pain/Endometriosis	Group Spokesperson Dr Hasthika Ellepola	Facilitated groups Power Point Presentation & Forum Discussion
1:15 pm	LUNCH	ALL	ALL

Maroon Group - Task 1

Natasha is 49 years old and works as a personal carer for elderly and disabled persons

- G4P3, BMI 28 kg/m2
- Stable de –facto relationship, one child still at home
- Smoker – 3-5/day, trying to cut back
- FHx Breast cancer in her mother
- Irregular light periods lasting 3-4days, with LMP 3/12 ago; increasing gaps between periods since last year
- Worsening hot flushes disturbing her sleep and at work when showering and assisting her clients
- Recognising that moody and snappy but attributing that to poor sleep.

Outline your approach

Metro South Health

Quality healthcare every day

Menopause Management

Dr Premjit Gill
Deputy Obstetrics and Gynaecology Department
Redland Hospital

ICARE² values

INTEGRITY COMPASSION ACCOUNTABILITY RESPECT ENGAGEMENT EXCELLENCE

Queensland Government

MENOPAUSE

Dr Premjit Gill
MBChB FRANZCOG AFRACMA
Redland Hospital
GP Education Day October 2024

OUTLINE

- Menopause overview
- Menopause management
  - MHT
  - Alternatives
  - Mental Health
  - Testosterone

WHAT IS MENOPAUSE?

- **PREMENOPAUSE**
  - Regular cycles
- **PERIMENOPAUSE**
  - Altered cycle frequency
  - Oligomenorrhoea
- **MENOPAUSE**
  - Final period (average age 51)
- **POSTMENOPAUSE**
  - No menstrual cycles >12/12

DIAGNOSIS OF MENOPAUSE

- >45yo
  - Amenorrhea >12 months
  - Symptoms of menopause
  - Not pregnant
- Does NOT routinely require a blood test
- >58yo

- 40-45yo: Early menopause
- <40yo: Primary ovarian insufficiency

DIAGNOSIS OF MENOPAUSE

- Amenorrhea with Mirena
  - FSH >30
- On OCP – hormone tests are uninformative

- Exclude other causes of amenorrhea
  - Pregnancy, hyperprolactinaemia, thyroid disease
- Exclude other causes for symptoms
  - Fatigue, mood change, hot flushes
  - TSH, FBE/Iron, Fasting blood glucose, Vit D

SYMPTOMS OF MENOPAUSE

Menstrual	Vasomotor	Psychological/ Cognitive	Genitourinary	Somatic
Shorter cycles	Hot flushes	Depression	Urinary incontinence	Headaches
Irregular bleeding	Night sweats	Irritability	Atrophy	Dizziness
Heavy bleeding	Sleep disturbance	Mood swings	Vaginal dryness	Palpitations
		Poor concentration	Dyspareunia	Joint pain
		Poor sleep	Sexual Dysfunction	Weight gain
		Decreased libido	Prolapse	
		Brain fog		

MENOPAUSE MANAGEMENT

menopause_doctor

2,653 posts **557K** followers

Dr Louise Newson

menopause_doctor

Doctor
GP & Menopause Specialist
Cannot give individualised advice
@newson.health @balancemenopause
Media: dln@borkowski.co.uk
www.drlouisenewson.co.uk + 4

The Lancet 2024 Series on menopause

Menopause is a life stage for half the world's population, but experiences vary hugely. *The Lancet* 2024 Series on menopause argues for a new approach supporting and empowering women transitioning this life stage.

MENOPAUSE MANAGEMENT

REVIEW

OPEN ACCESS Check for updates

The 2023 Practitioner's Toolkit for Managing Menopause

S. R. Davis[a,b], S. Taylor[a], C. Hemachandra[a,c], K. Magraith[d,e], P. R. Ebeling[f], F. Jane[a] and R. M. Islam[a]

[a]Women's Health Research Program, School of Public Health and Preventive Medicine, Monash University, Melbourne, VIC, Australia; [b]Department of Endocrinology and Diabetes, Alfred Health, Melbourne, VIC, Australia; [c]Ministry of Health, Colombo, Sri Lanka; [d]Cascade Road General Practice, TAS, Australia; [e]College of Health and Medicine, University of Tasmania, Hobart, TAS, Australia; [f]Department of Medicine, School of Clinical Sciences at Monash Health, Monash University, Clayton, VIC, Australia

LIFESTYLE MANAGEMENT

- Stress reduction
- Regular exercise
- Optimal weight management
- Avoidance of smoking
- Reducing caffeine intake
- Reducing alcohol consumption

COMPLEMENTARY MEDICINE

Medicine/ Therapy	Symptom	Comments	Recommendation
Botanical/herbal/vitamin supplements			
Vitamin E	Hot flushes	Vitamin E can decrease the number of hot flushes by one per day.	
St John's Wort	Mood symptoms	St John's Wort can improve mood and may help with mild depression. This therapy interacts with many prescription medicines.	
Soy isoflavones or phyto-oestrogens	Menopausal symptoms	May help hot flushes. Not helpful for sleep. Do not take it if you can't take prescribed MHT or HRT for safety reasons.	
Wild yam cream or progesterone cream	Endometrial (lining of the uterus) protection	No evidence that it is effective.	
Red clover	Menopausal symptoms	Inconsistent evidence that it is effective.	
Omega-3 supplements	Hot flushes	No evidence that it is effective.	
Black cohosh	Menopausal symptoms	Inconsistent evidence that it is effective and possible safety concerns.	
Evening primrose oil	Hot flushes	No evidence that it is effective.	

Medicine/ Therapy	Symptom	Comments	Recommendation
Mind-body therapies			
Acupuncture	Hot flushes	Studies show that acupuncture is no better than sham acupuncture. May help sleep.	
Cognitive behavioural therapy	Menopausal symptoms	Cognitive behavioural therapy (CBT) and mindfulness-based stress reduction can help some women with menopausal symptoms (sleep/hot flushes/mood).	
Hypnosis	Menopausal symptoms	Hypnosis might be helpful for some women but the evidence is inconsistent.	
Yoga	Menopausal symptoms	Yoga might be helpful for some women but the evidence is inconsistent.	
Homeopathy	Menopausal symptoms	No evidence that is it effective.	
Magnetic therapy	Menopausal symptoms	No evidence that is it effective.	
Other			
Bioidentical compounded hormone therapy	Menopausal symptoms	Do not take it if you can't take prescribed menopausal hormone therapy (MHT) or hormone replacement therapy (HRT) for safety reasons.	

Information obtained from the Cancer Australia website (www.canceraustralia.gov.au/publications-and-resources/clinical-practice-guidelines/menopausal-guidelines) and the North American Menopause Society (Nonhormonal management of menopause-associated vasomotor symptoms: 2015 position statement of The North American Menopause Society).

NON-HORMONAL

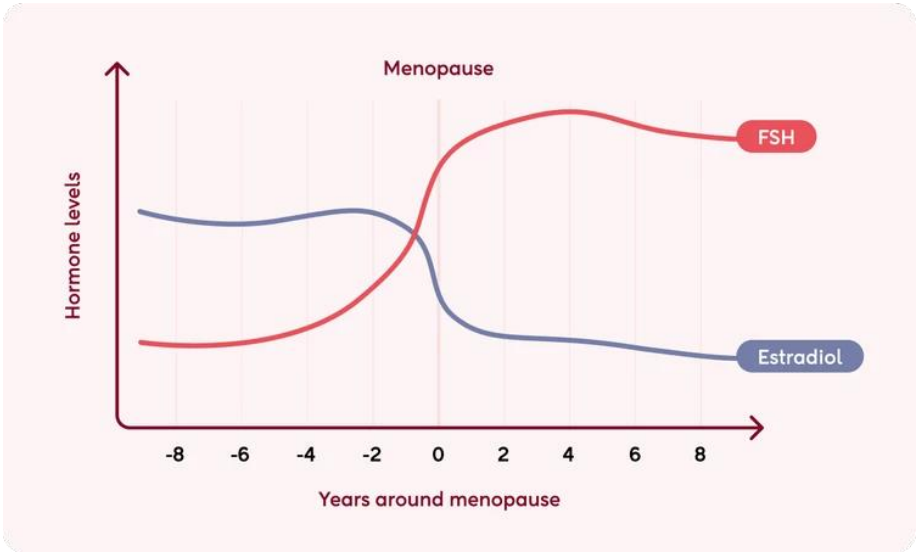
Table 1. Non-hormonal medications for treatment of menopausal vasomotor symptoms[21]		
Medication	**Suggested dosage**	**Common adverse effects**
SSRIs and SNRIs		
Escitalopram	10–20 mg/day	Nausea, drowsiness, sexual dysfunction*
Paroxetine†	10–20 mg/day	
Venlafaxine	37.5–150 mg/day	
Desvenlafaxine	25–150 mg/day	
Other medications		
Gabapentin	100 mg at night, slowly titrating to maximum 300 mg three times per day	Dizziness, drowsiness
Pregabalin	75 mg at night, slowly titrating to maximum 150 mg twice daily	Dizziness, drowsiness, nausea, headache
Clonidine	25 mcg twice daily, slowly titrating to maximum 75 mcg twice daily	Dry mouth, drowsiness, visual disturbance

**Adverse effects vary between antidepressants and between patients, so a trial of more than one medication may be helpful.*
†Do not prescribe paroxetine to women taking tamoxifen.[31]
SSRI, selective serotonin reuptake inhibitors; SNRIs, serotonin–noradrenaline reuptake inhibitors

Magraith, K 2019

MENOPAUSE HORMONE THERAPY

- Menopausal symptoms are caused by declining oestrogen levels



- Estrogen replacement has been shown to improve some menopausal symptoms
- Unopposed oestrogen (without progesterone) increases the risk of endometrial hyperplasia and cancer in women with a uterus
- Women without a uterus do not require progesterone

MHT – WHEN TO PRESCRIBE

- Menopausal symptoms (peri/post menopause)
  - Especially vasomotor
- MHT is >80% effective in improving vasomotor symptoms

- Early or premature menopause (<45yo)
  - Continue to age 50

- Within 5-10yrs of last period

- NOT indicated for CVD, dementia/cognitive prevention
- Osteoporosis only if non-estrogen therapies are unsuitable

MHT – WHEN TO PRESCRIBE

- MHT improves
  - Vasomotor symptoms
  - Urogenital symptoms
- Symptoms that may improve
  - Psychological symptoms
    - Low mood, not clinical depression
    - Anxiety/irritability
  - Disturbed sleep with frequent awakenings
  - Lessened sexual desire
  - New onset MSK symptoms
- Insufficient evidence/ Nil objective improvement
  - Cognitive symptoms – impaired memory and concentration
  - Fatigue, headaches
  - Other menopausal symptoms "may or may not improve with MHT"

BEFORE STARTING MHT

- History
  - Symptoms
  - Contraindications
  - CVD/ VTE/ Breast Ca risk factors
- Opportunistic screening:
  - Mammogram/cholesterol/lipid profile/BP/BMI/fasting glucose
- Cervical screening test

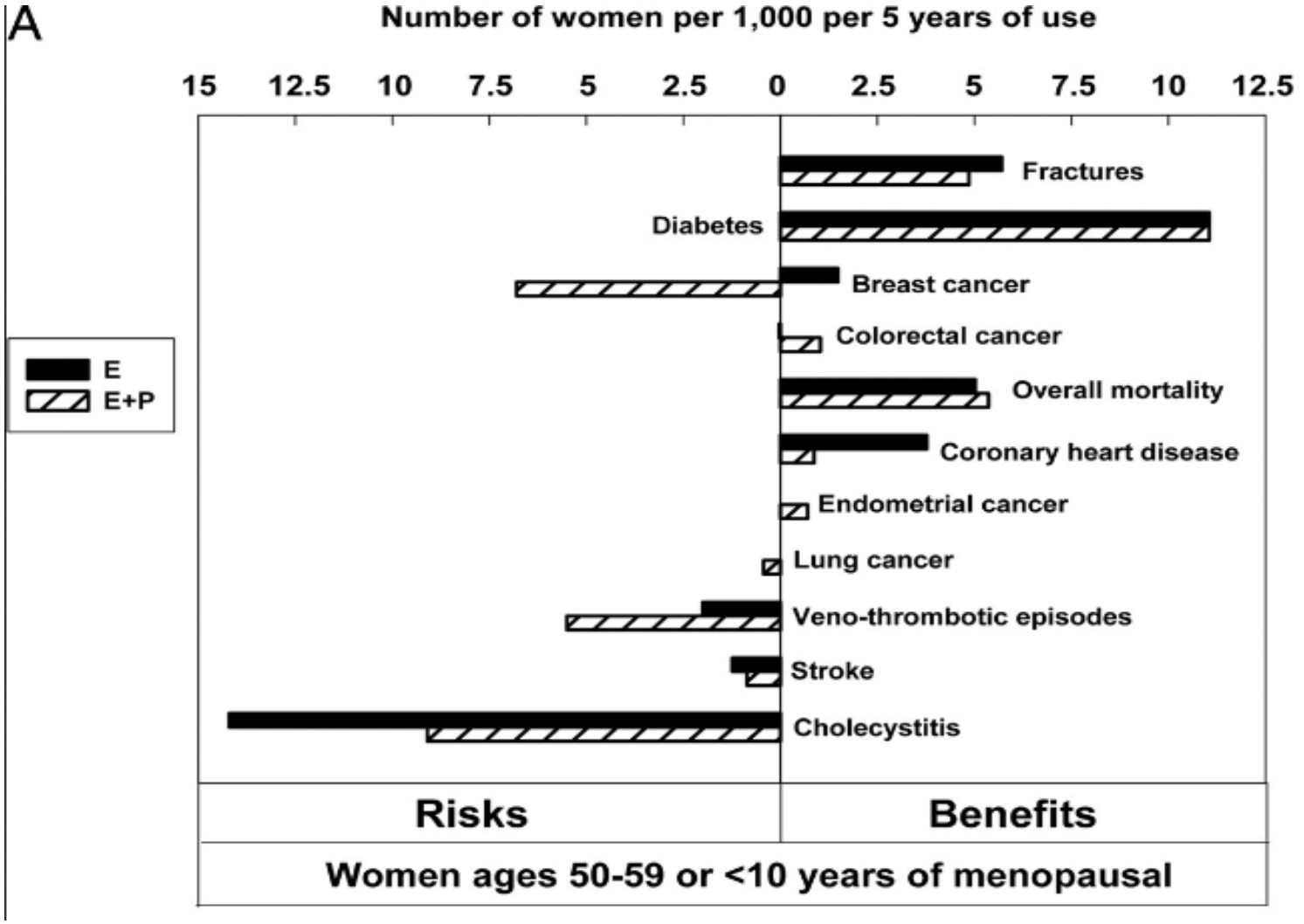
- Do not require FSH/ Estradiol level

CONTRAINDICATIONS TO MHT

- Breast cancer or other estrogen dependent cancers
- Thrombophilias or personal history of VTE
- Undiagnosed vaginal bleeding
- Active liver disease
- Uncontrolled HTN
- Active cardiovascular disease or high risk
- >10yrs since LMP

- NOT CI: Smoking, well controlled HTN, migraines, family hx of breast cancer

MHT – RISKS & BENEFITS



- Santen RJ et al. JCEM 2010.

BREAST CANCER RISK

- Combination oestrogen + progesterone >5 yrs increases risk
  - Risk is based on time of initiation, duration of use, BMI, family history, type of progesterone

MHT use for 5 years	Breast cancer risk
No MHT	6.3%
Estrogen only use	6.8%
Intermittent progesterone use	7.7%
Continuous combined use	8.3%

CGHFBC – Lancet 2019

Lifestyle risk factors		Absolute excess risk per 1000 women over 5 years aged 50-59
Postmenopausal obesity	Overweight vs healthy weight[a]	+4
	Obese vs healthy weight[a]	+10
Alcohol	4-6 units day^{-1}	+8
	≥6 units day^{-1}	+11
Unopposed oestrogen use for 5 years	WHI study 2020	-6
	NICE Menopause Guidance 2015	+3
	CGHFBC 2019	+3
Combined HRT use for 5 years	WHI study 2020	+8
	NICE Menopause Guidance 2015	+9
	CGHFBC 2019	+10

[a] Healthy weight, body mass index (BMI) <25 kg/m^2, overweight BMI 25–29.9 kg/m^2, obese BMI ≥30 kg/m^2

British Menopause Society 2022

MHT – OESTROGEN

- Oral
  - CEE – low/medium
  - 17B oestrodial (bioidentical) – low, medium
- Transdermal
  - Patch - Low, medium, high
  - Gel (pump) – Low (1), medium (2), high (3-4)
  - Preferred if: absorption, high TG, VTE risk
- Dose
  - Low/medium usually enough
  - High reserved for POI

MHT – PROGESTOGEN

- Medroxyprogesterone Acetate
  - 2.5mg if continuous
  - 5mg if cyclic
- Micronized 100mcg if low/standard EE; 200mcg If cyclical or high dose
  - Can help with sleep
  - Can be taken vaginally
  - Lower breast cancer risk
- Norethisterone – may be better if endo
- LNG IUS - Mirena – only valid for 5 yrs, no data for Kyleena

MHT – COCP

- Provides contraception, cycle control, improves VMS, prevents bone loss, acne
- Assess risk: smoking, BP, lipid profile, migraine with aura, thrombosis/CVD risk, BMI

- Low dose ethinylestradiol (20ug)
- Estradiol-containing OCP have more neutral BP effects (Zoely)
- Estetrol better lipid effects (Nextstellis)

TIBOLONE

- Synthetic steroid (progestogen)
  - Post – absorption: metabolites have oestrogenic, progestogenic and androgenic properties
- Used for menopausal symptoms and prevent osteoporosis
- May have benefits for mood and sexual function
- Should be started >12/12 after LMP
  - Otherwise may be associated with irregular bleeding
- Can be used in women with or without a uterus
- Risks:
  - Stroke – >60yo; Breast cancer – inconclusive

MHT – WHAT TO PRESCRIBE

- Start low, review after 6-8 weeks
- Has uterus – needs progesterone
- <12 months since LMP – cyclical; otherwise continuous
- Mirena (contraception, endometrial protection, bleeding) + transdermal low dose estrogen
- OCP
- Transdermal
- Consider micronized progesterone

MHT – WHAT TO PRESCRIBE

- Combined:
  - Cyclical: Estalis Sequi 50/140 OR Estrogel Pro (2 pumps; 200mg 12 days)
  - Continuous: Estalis Conti 50/140 OR Estrogel Pro (2 pumps, 100mg daily)
  - Mirena + Estrogen patch OR Estrogel
- Estrogen only
  - Estraderm (or Estradot)
  - Estrogel
- Mood/low libido (>12 months LMP) – consider Tibolone

MHT – WHAT TO PRESCRIBE

CYCLIC MENOPAUSAL HORMONE THERAPY (MHT)

Use continuous oestrogen and cyclic progestogen combinations at peri-menopause or if less than 12 months amenorrhoea

LOW DOSE		
PRODUCT	**PRESENTATION**	**COMPOSITION**
Femoston	tablet	1mg oestradiol/10mg dydrogesterone
Estrogel Pro*	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	1 pump (0.75mg oestradiol) daily, and 2 capsules (200mg) micronised progesterone orally for 12 days out of a 28-day cycle
MEDIUM DOSE		
Trisequens*	tablet	1 and 2mg oestradiol/1mg norethisterone
Femoston	tablet	2mg oestradiol/10mg dydrogesterone
Estalis sequi 50/140)	transdermal patch	50mcg 17 B oestradiol/140mcg norethisterone acetate (twice weekly application)
Estalis sequi 50/250 (same oestrogen, more progestogen than Estalis sequi 50/140)	transdermal patch	50mcg 17 B oestradiol/250mcg norethisterone acetate (twice weekly application)
Estrogel Pro*	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	2 pumps (1.5mg oestradiol) daily, and 2 capsules (200mg) micronised progesterone orally for 12 days out of a 28-day cycle

CONTINUOUS COMBINED MENOPAUSAL HORMONE THERAPY (MHT)

Should be used if 12 months since LMP or after 12 months cyclical MHT

LOW DOSE		
PRODUCT	**PRESENTATION**	**COMPOSITION**
Angeliq1/2*	tablet	1mg oestradiol/2mg drospirenone
Femoston-conti	tablet	1mg oestradiol/5mg dydrogesterone
Kliovance*	tablet	1mg oestradiol/0.5mg norethistrone
Estrogel Pro*	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	1 pump (0.75mg oestradiol) daily, and 1 capsule (100mg) micronised progesterone orally for 25 days out of a 28-day cycle^
OTHER LOW DOSE HORMONAL OPTIONS		
Livial*, Xyvion*	tablet	2.5mg tibolone
Duavive* (oestrogen/SERM combination)	tablet	0.45mg conjugated equine oestrogens / 20mg bazedoxifene
MEDIUM DOSE		
Kliogest*	tablet	2mg oestradiol/1mg norethistrone
Estalis continuous 50/140	transdermal patch	50mcg 17 B oestradiol/140mcg norethisterone acetate (twice weeklyapplication)
Estalis continuous 50/250 (same oestrogen, more progestogen than Estalis continuous 50/140)	transdermal patch	50mcg 17 B oestradiol/250mcg norethisterone acetate (twice weekly application)
Estrogel Pro*	Combination pack of oestradiol transdermal gel, with micronised progesterone capsules.	2 pumps (1.5mg oestradiol) daily, and 1 capsule (100mg) micronised progesterone orally for 25 days out of a 28-day cycle^

^Can be given daily if adherence is an issue

Australasian Menopause Society

MHT – WHAT TO PRESCRIBE

OESTROGEN ONLY THERAPY

Only use these if patient has had a hysterectomy or in combination with a progestogen or Mirena if intact uterus

LOW DOSE		
PRODUCT	**PRESENTATION**	**COMPOSITION**
Estrofem*	tablet	1mg 17 B oestradiol
Progynova	tablet	1mg oestradiol valerate
Premarin*	tablet	0.3mg conjugated equine oestrogen
Climara 25	transdermal patch	25mcg/24hrs 17 B oestradiol (weekly application)
Estradot 25 or 37.5	transdermal patch	25 or 37.5mcg/24hrs 17B oestradiol (twice weekly application)
Estraderm 25 MX	transdermal patch	25mcg/24hrs 17B oestradiol (twice weekly application)
Estrogel*	gel	0.75mg oestradiol = 1 pump
MEDIUM DOSE		
Estrofem*, Zumenon	tablet	2mg 17B oestradiol
Progynova	tablet	2mg oestradiol valerate
Premarin*	tablet	0.625mg conjugated equine oestrogens
Climara 50	transdermal patch	50mcg/24hours 17B oestradiol (weekly application)
Estradot 50, Estraderm 50 MX	transdermal patch	50mcg/24 hours 17B oestradiol (twice weekly application)
Sandrena	gel	1mg oestradiol (daily application)
Estrogel*	gel	1.5mg oestradiol = 2 pumps
HIGH DOSE		
Climara 75	transdermal patch	75mcg/24hours oestradiol (weekly application)
Estradot 75, Estradot 100	transdermal patch	75 or 100mcg/24 hours (twice weekly application)
Climara 100	transdermal patch	100mcg/24hours oestradiol (weekly application)
Estraderm 100 MX	transdermal patch	100mcg/24hours 17B oestradiol (twice weekly application)
Estrogel*	gel	2.25mg oestradiol = 3 pumps or 3.0mg oestradiol = 4 pumps

OESTROGEN ONLY VAGINAL THERAPY

If prescribing vaginal oestrogen rather than systemic hormone therapy, a progestogen is not required.

PRODUCT	**PRESENTATION**	**COMPOSITION**
Ovestin	cream	1mg/g oestriol
Ovestin	pessary	0.5mg oestriol
Vagifem Low	pessary	10mcg oestradiol

MHT – WHAT TO PRESCRIBE

PROGESTOGEN

Suggested alternative doses for use with the oestrogen preparations above where fixed dose therapy is not suitable

LOW DOSE for use with low dose oestrogen		
PRODUCT	**PRESENTATION**	**COMPOSITION**
Provera (1/2 of 5mg tablet)	tablet	2.5mg medroxyprogesterone acetate
Provera 2.5mg tablet*	tablet	2.5mg medroxyprogesterone acetate
Primolut N (1/4 of 5mg tablet)	tablet	1.25 mg norethisterone
Prometrium*	capsule	100mg micronised progesterone orally for 25 days out of a 28-day cycle^ or 200mg orally daily for 12 days out of a 28-day cycle
Mirena*(PBS indication for contraception/ menorrhagia)	device (5 years)	20mcg/24hrs levonorgestrel
MEDIUM DOSE for use with medium dose oestrogen		
PRODUCT	**PRESENTATION**	**COMPOSITION**
Primolut N (1/4 of 5mg tablet)	tablet	1.25 mg norethisterone
Provera, Ralovera	tablet	5mg medroxyprogesterone acetate
Prometrium*	capsule	100mg micronised progesterone orally for 25 days out of a 28-day cycle^ or 200mg orally for 12 days out of a 28-day cycle
Mirena*(PBS indication for contraception/menorrhagia)	device	20mcg/24hrs levonorgestrel (5 years)
HIGHER DOSE (for use in cyclical therapy or continuous therapy with high dose oestrogen)		
PRODUCT	**PRESENTATION**	**COMPOSITION**
Primolut N (1/2 5mg tablet)	tablet	2.5mg norethisterone
Provera, Ralovera	tablet	10mg medroxyprogesterone acetate
Prometrium*	capsule	200mg orally daily for 12 days out of a 28-day cycle. Safe continuous dose unknown due to insufficient data
Mirena*(PBS indication for contraception/menorrhagia)	device	20mcg/24hrs levonorgestrel (5 years)

^Can be given daily if adherence is an issue

SIDE EFFECTS

- https://www.nhs.uk/medicines/hormone-replacement-therapy-hrt/side-effects-of-hormone-replacement-therapy-hrt/

Common side effects

These common side effects of oestrogen tablets, patches, gel and spray happen in more than 1 in 100 people. There are things you can do to help cope with them:

- ▶ Headaches
- ▶ Breast pain or tenderness
- ▶ Unexpected vaginal bleeding or spotting
- ▶ Feeling sick (nausea)
- ▶ Mood changes, including low mood or depression
- ▶ Leg cramps
- ▶ Mild rash or itching
- ▶ Diarrhoea
- ▶ Hair loss

Common side effects

These common side effects of oestrogen tablets, patches, gel and spray happen in more than 1 in 100 people. There are things you can do to help cope with them:

- ▶ Headaches
- ▶ Breast pain or tenderness
- ▶ Unexpected vaginal bleeding or spotting
- ▼ Feeling sick (nausea)

  If you're taking oestrogen tablets, try taking them with food. Stick to simple meals and do not eat rich or spicy foods.

  This side effect should wear off after a few days as your body gets used to the medicine. If it lasts more than a week, speak to your doctor. You may need to change your dose or switch to a different type of HRT.

CYCLICAL TO CONTINUOUS

- No strong evidence
- Age >55
- >12 months since LMP
- After 12 months of cyclical

- If irregular bleeding, can swap back to cyclical

CONTRACEPTION CONSIDERATIONS

- MHT is NOT contraceptive

- OCP if suitable
- Mirena
- Tubal ligation
- Barrier method

OTHER CONSIDERATIONS

- Endometriosis – use progesterone
- CVD, Liver disease/gallstones, Obesity - transdermal
- Migraines – transdermal, avoid oral progestogen, continuous
- Mastalgia – lower dose, tibolone

- Vaginal symptoms – vaginal oestrogen cream/pessary
  - Okay to use with systemic MHT
  - Generally okay with cancer diagnosis

WEANING MHT

- No strong evidence re: duration/age
  - Continue until age 50 (if started prior to age 45)

  - Lowest effective dose
  - Risk/benefit discussion
- Stop if develops CI
- Sudden vs gradual
- 50% recurrence of VMS after stopping
  - Abrupt – worse in first 3 months
  - Gradual (over 3-6 months) – worse at 6 months
  - No difference at 9-12 months
  - ~40% re-start therapy
- 20% of women continue to have symptoms in 60's and 70's

GOOD RESOURCES

- Menopause Society
  - Australasian
  - British
  - International
- 2023 Practitioner's Toolkit for Managing Menopause

- Australasian Menopause Society → Consumer Information → Fact Sheets
  - https://www.menopause.org.au/health-info/fact-sheets

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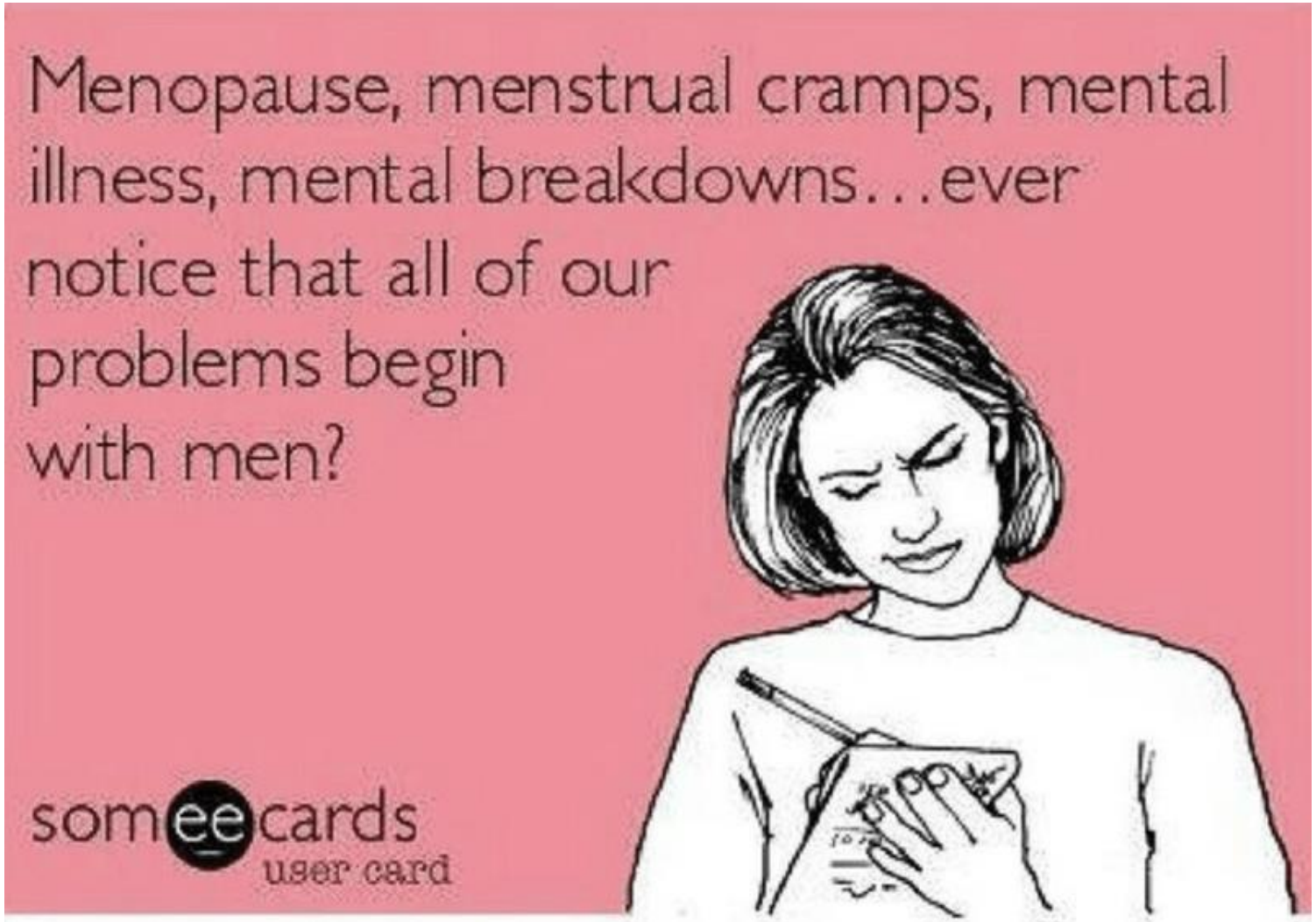
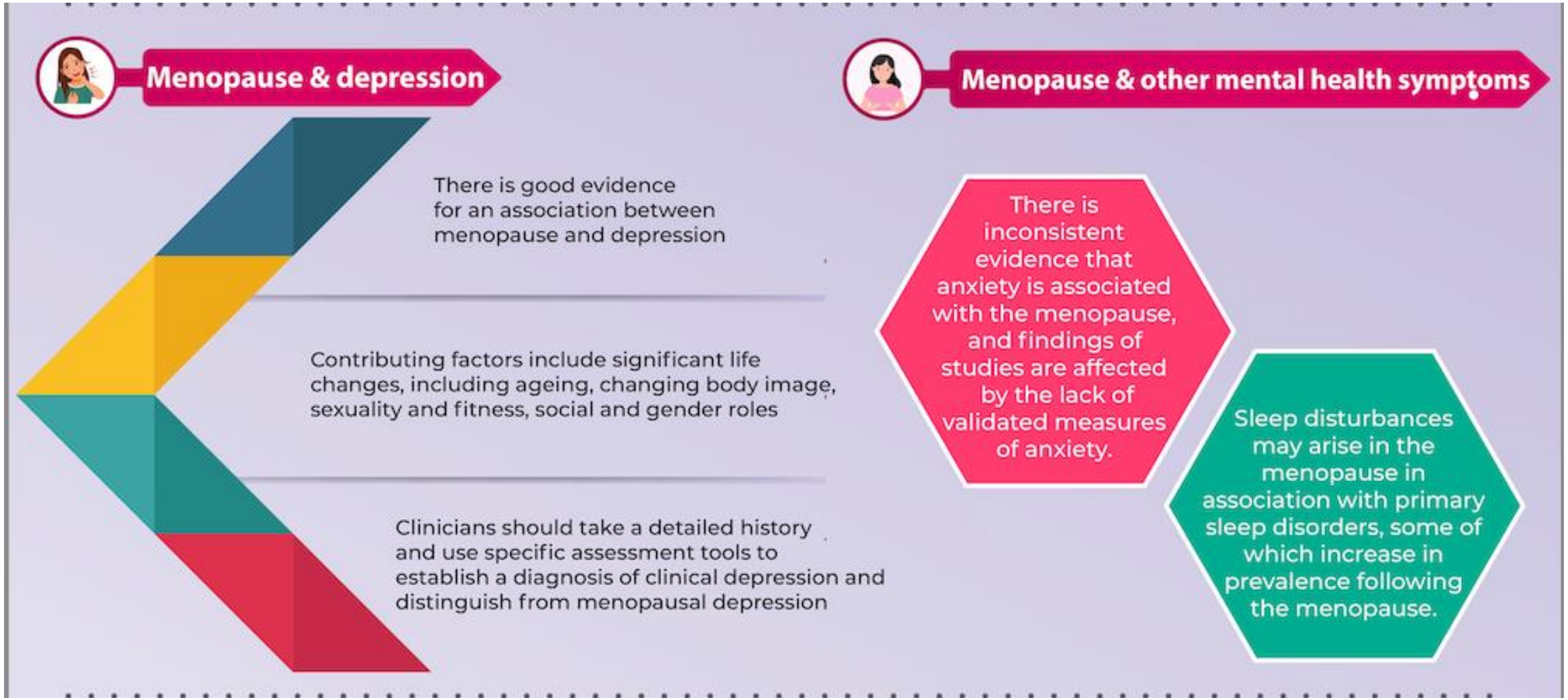

Menopause, menstrual cramps, mental illness, mental breakdowns…ever notice that all of our problems begin with men?
someecards
user card

MENTAL HEALTH



Swaminathan 2023

MENTAL HEALTH

Management of menopausal depression

Empowering women to seek advice and support at the onset of psychiatric symptoms is crucial

There are 3 main treatment aspects:

- hormone replacement therapy (HRT)
- antidepressants
- cognitive behavioural therapy (CBT)

Creating awareness among healthcare professionals for early diagnosis and effective management of menopause associated psychiatric illnesses is key.

There is some evidence that lifestyle changes, including exercise, reduced alcohol intake, sleep hygiene and dietary changes may be of benefit.

Swaminathan 2023

SEXUAL DISORDERS

- Multifactorial – biological, psychological, interpersonal, sociocultural
- FSD – problems with sexual response, desire, orgasm or pain
- Hypoactive Sexual Desire Disorder (HSDD)
  - Reduced/absent sexual desire that causes the patient distress
  - Present for >6 months in more that 75% of sexual encounters
  - Up to 32% of women age 40-64
- HSDD vs life
  - For women, sexual energy is excess energy
- Reason for presenting now?

Vigneswaran 2022

ANDROGEN THERAPY

- Tibolone
- AndroFeme 1
  - 10% testosterone cream
  - TGA approved for HSDD
- Pre-treatment: baseline total testosterone and SHBG levels
- Starting dose is 0.5mL (1 pump) daily on thigh/buttocks/back of calf
- Repeat 4-6 weeks later to exclude high levels from treatment
- Can increase to 1mL daily
- Initial improvement takes 4-6 weeks

AMS, Vigneswaran 2022

ANDROGEN THERAPY

Strong evidence

Diagnosis of HSDD in clinical practice should be based on thorough clinical assessment guided by available diagnostic criteria.

Treatment of HSDD should follow a biopsychosocial model.

Testosterone therapy exerts a beneficial effect on sexual function:

- Number of satisfying sexual events per month
- Increased sexual desire, arousal, orgasmic function and responsiveness
- Reduction in sexual concerns, including sexual distress

Systemic testosterone therapy in physiological doses, i.e. that of premenopausal women, is associated with mild increases in acne and hair grown but no other androgenic side effects.

Oral testosterone therapy is associated with adverse lipid profiles, an effect that is not seen with transdermal testosterone over the short term.

Vigneswaran 2022

ANDROGEN THERAPY

Limited evidence

A baseline total testosterone concentration should be measured before starting treatment and repeated 6 weeks after commencement. Signs of androgen excess can be screened for with 6-monthly levels.

Treatment should be stopped if no benefit after 6 months.

Testosterone may improve wellbeing but data are inconclusive.

Available data to date show that short-term transdermal testosterone therapy does not appear to impact breask cancer risk, but RCT data for long-term breast cancer risk is insufficient.

Weak/no evidence

The association between endogenous androgen concentrations and sexual function in women is uncertain, and there is no cut-off level that can be used to differentiate women with or without sexual dysfunction.

Insufficient evidence that testosterone enhances cognitive performance or improves depressed mood.

Insufficient evidence that testosterone improves musculoskeletal outcomes, including bone mineral density.

A nonsignificant trend for increased deep vein thrombosis has been seen with transdermal testosterone; however, this could be associated with estrogen therapy.

Safety data for testosterone therapy beyond 24 months is not available.

Vigneswaran 2022

ANDROGEN THERAPY

What about the potential wider benefits of testosterone?

Randomised clinical trials of testosterone to date have not demonstrated the beneficial effects of testosterone therapy for cognition, mood, energy and musculoskeletal health. Further better designed studies are required with these health issues as primary outcome measures as some individuals report improvement of these symptoms. Until these data are available, the primary indication for testosterone should therefore be for HSDD following a biopsychosocial approach.

ANDROGEN THERAPY

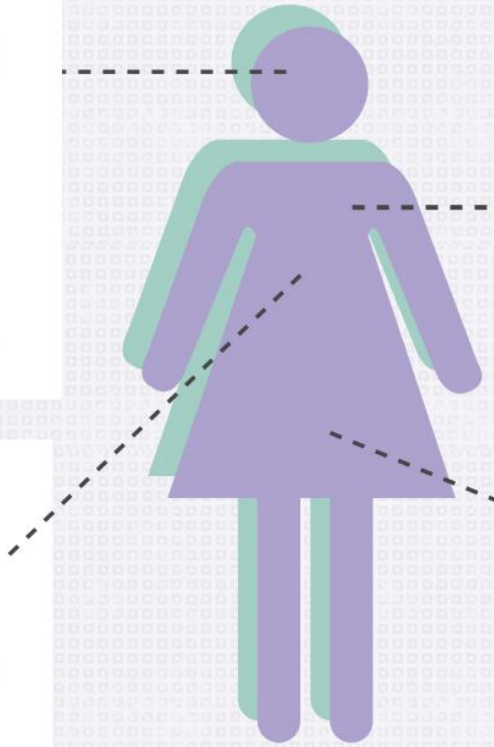
Safety and side effects of androgen therapy

Androgenic side effects

- Hirsutism (3-20%)
- Acne (4.6-7.5%)
- Alopecia (very rare)
- Virilisation (very rare)
- Side effects are dose dependent and cessation results in prompt resolution.

Cardiovascular safety

Trials have not shown an increase in coronary artery disease, stroke or thrombosis with testosterone therapy, but studies were not of sufficient size to be conclusive.



Breast safety

Lifetime exposure to estrogen and progesterone are associated with breast cancer, but an association with androgens has not been determined.

Experimental and observational data suggest that testosterone therapy does not increase the risk of breast cancer, but robust evidence on this is lacking.

Endometrial safety

Current data do not suggest any increased risk of endometrial cancer in association with testosterone therapy.

Vigneswaran 2022

Blue Group – Task 1

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

Metro South Health

Quality healthcare every day

Pelvic Organ Prolapse

Dr YuHwee Tan, Urogynaecologist

Queensland Pelvic Floor Services (Greenslopes Hospital) and Gold Coast HHS and the Queensland Pelvic Mesh Service

ICARE² values

INTEGRITY COMPASSION ACCOUNTABILITY RESPECT ENGAGEMENT EXCELLENCE

Queensland Government

Blue Group – Task 1

Helen is a healthy 46-year-old - BMI 36 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

PELVIC ORGAN PROLAPSE: AN OVERVIEW

DR YU HWEE TAN, MBCHB FRANZCOG CU
UROGYNAECOLOGIST

QUEENSLAND PELVIC FLOOR SERVICES, GREENSLOPES PRIVATE HOSPITAL
GOLD COAST HEALTH

Queensland Pelvicfloorservices

Conflicts of interest: Nil

Queensland Pelvicfloor services

HISTORY

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

- **Bladder symptoms**
  - Overactive bladder symptoms
  - Voiding symptoms

- **Bowel symptoms**
  - Obstructed defecation symptoms

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

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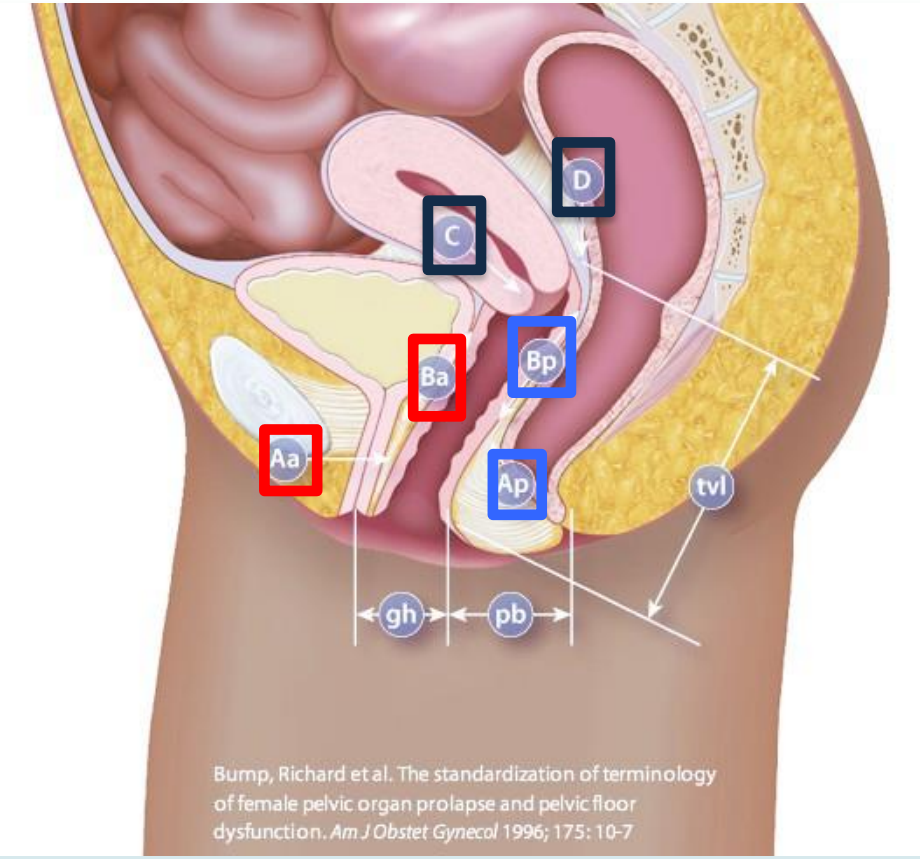
Urogynaecology Exam : POPQ



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**

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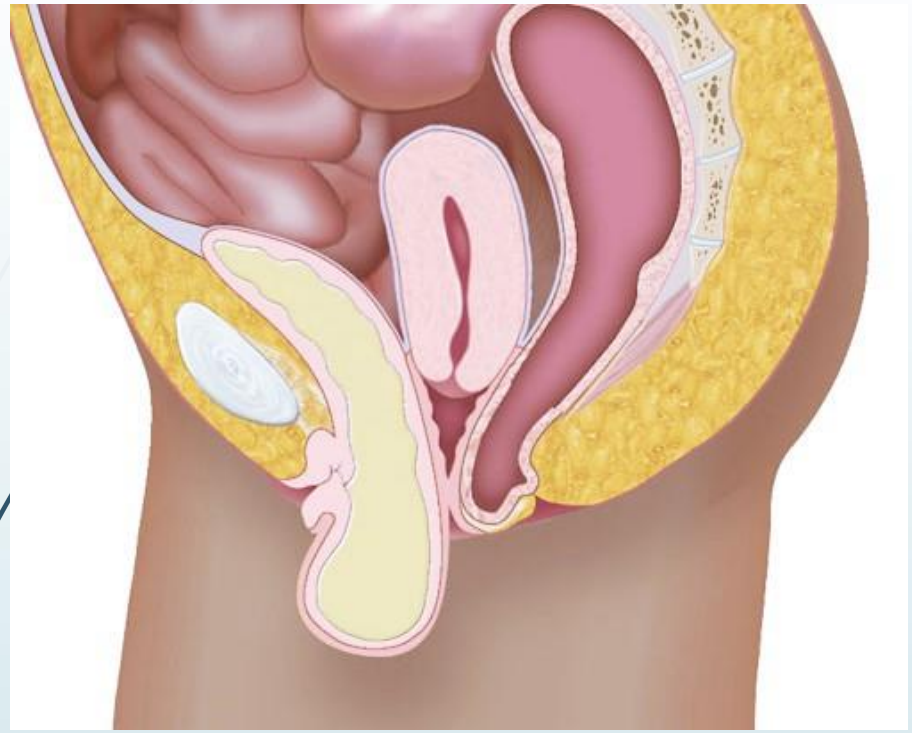
EXAMINATION: ANTERIOR WALL



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

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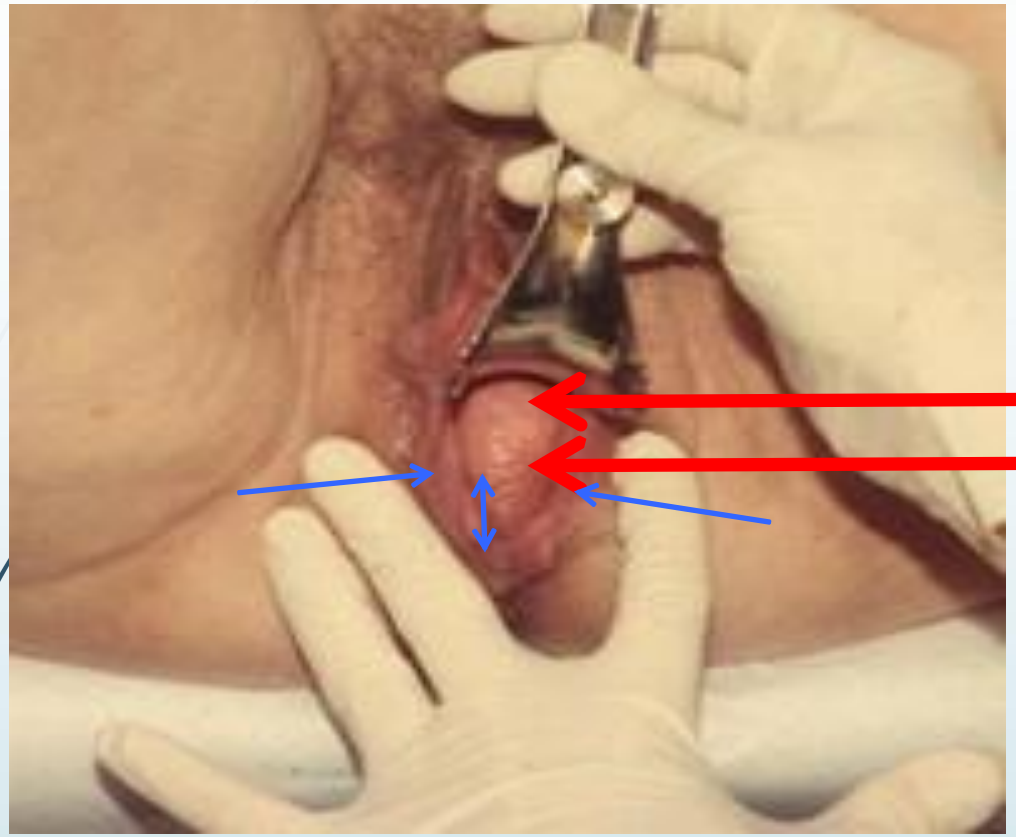
Urogynaecology exam: posterior wall



Bp
Ap
**** 3cm from posterior fourchette**

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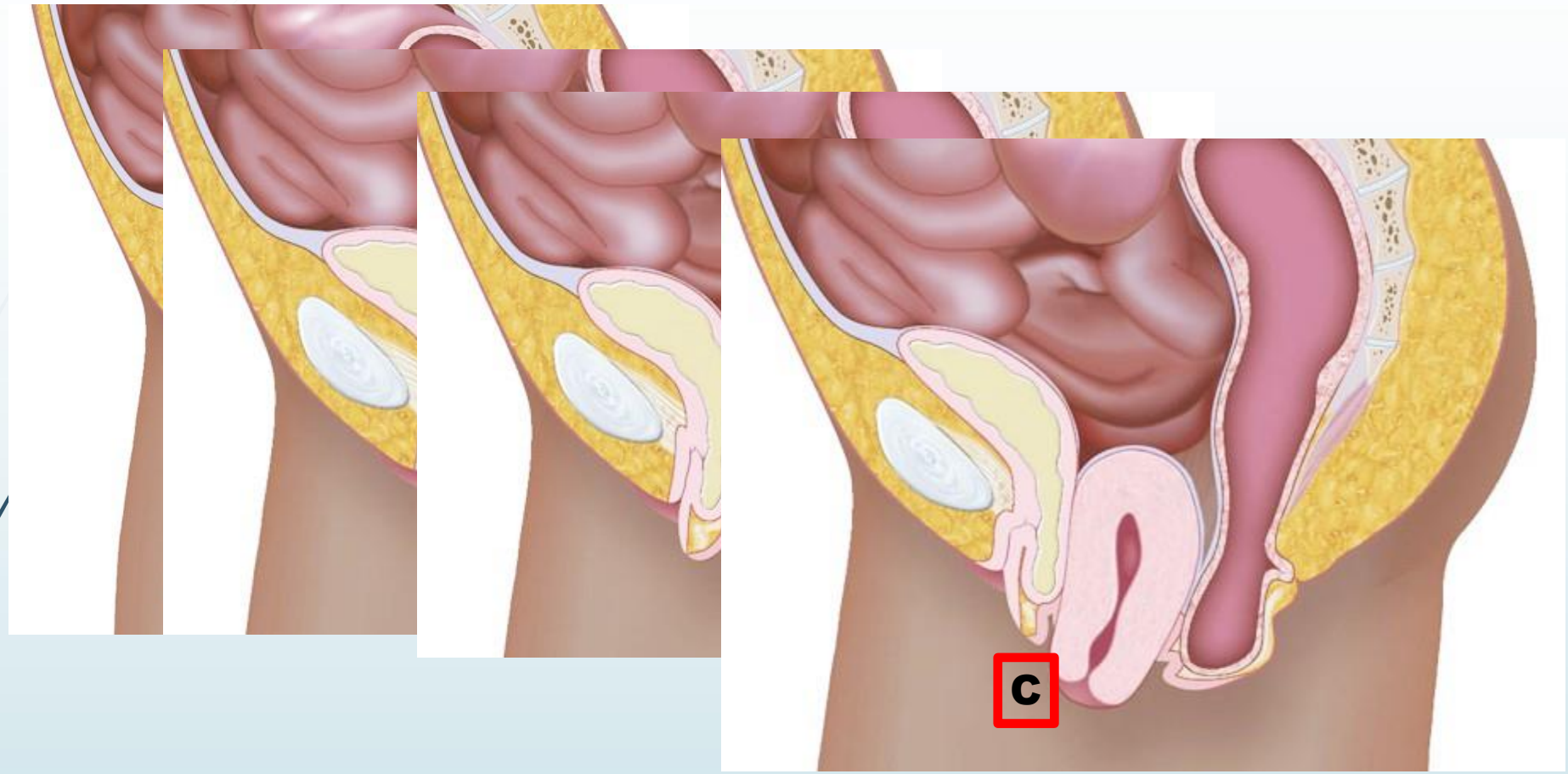
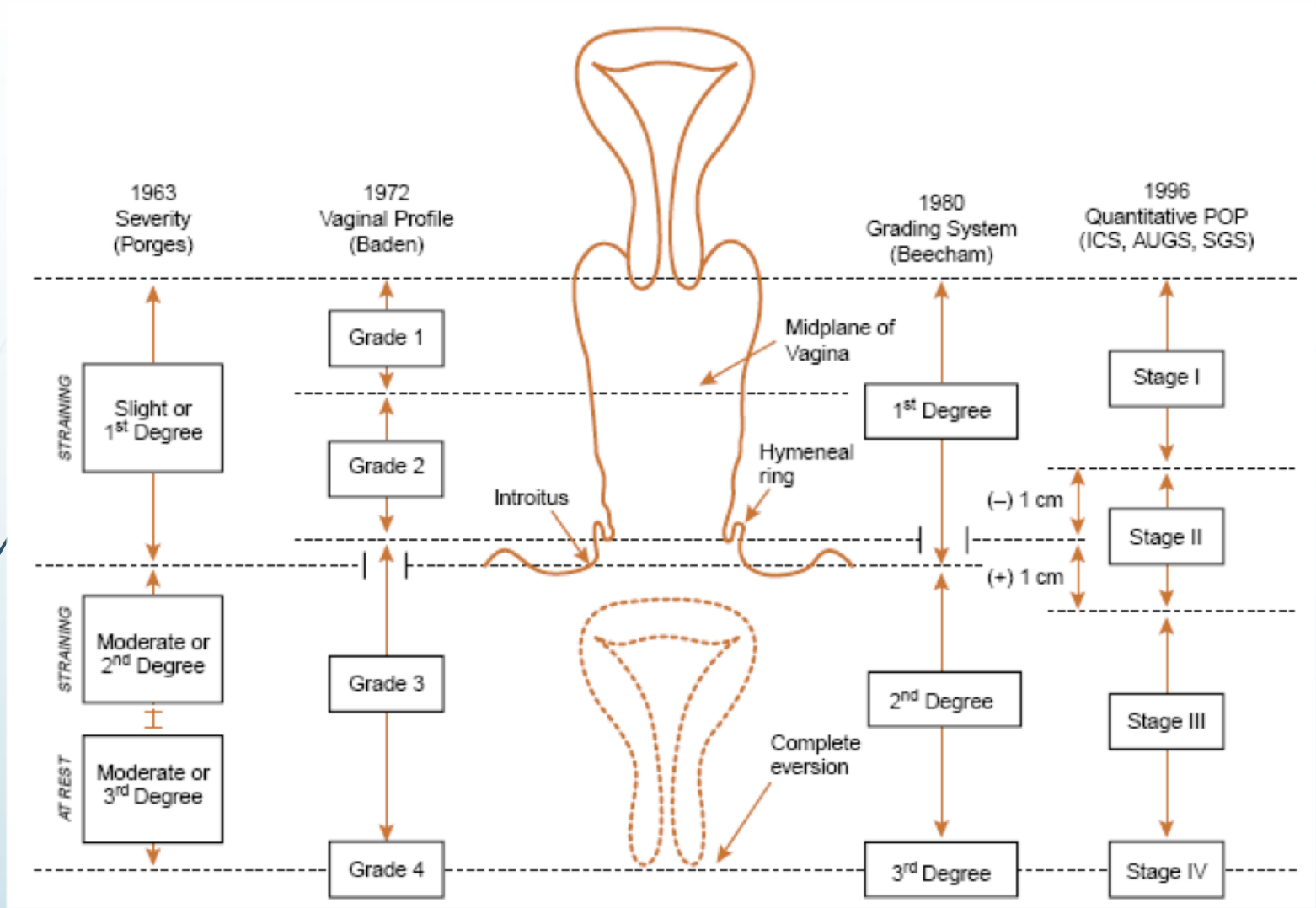
Urogynaecology exam: apical



Prolapse assessment/staging



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Investigations

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

- **Pelvic floor ultrasound NOT necessarily helpful**

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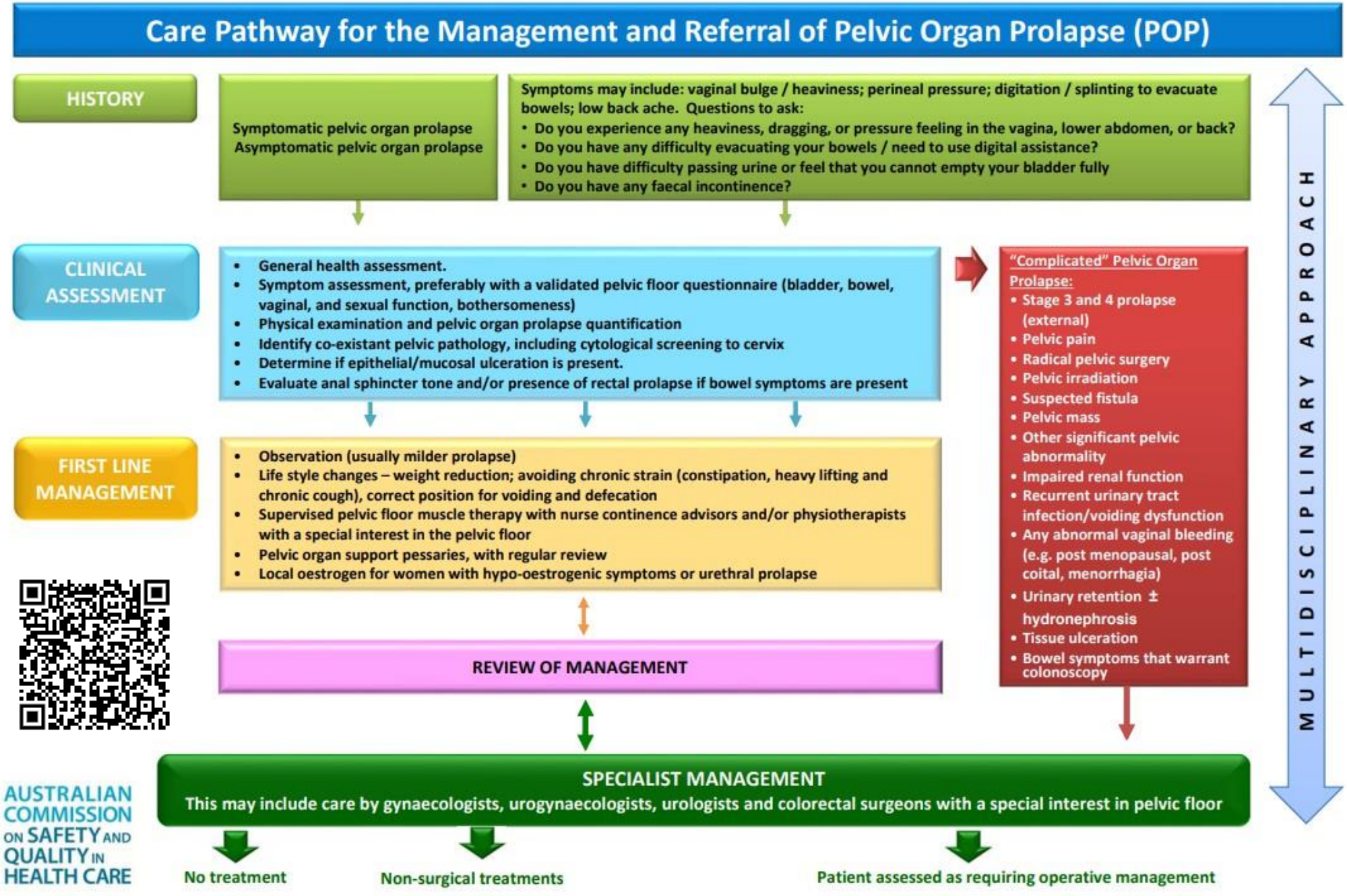
CARE PATHWAY for the Management and Referral of Pelvic Organ Prolapse – Australian Health Commission



RED FLAGS

REFER TO GYNAE/UROGYN

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Management of prolapse

- **Expectant**
- **Conservative**
  - When to consider?
    - Child-bearing, not completed family
    - Very frail
    - Unwilling to undergo surgery
- Aims of conservative treatment:

1. Reduce symptoms and severity of the impact of prolapse
2. Avert/delay need for surgery
3. Provide therapeutic/diagnostic aid

- **Surgical**

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Management of prolapse: conservative

- **Lifestyle interventions – ICI 2023**
- Studies support association between heavy lifting jobs and prolapse
- Studies support correlation between increasing BMI with prolapse
  - weight loss could be considered to improve POP symptoms/severity (Grade C)
- Significant association with prolapse symptoms and defecatory dysfunction but not stage of prolapse

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Management of POP: physiotherapy/PFMT

- **ICI 2023**
- PFMT prevents POP symptoms which occur in longer term after childbirth but not immediately after (Level 1)
- PFMT can be offered to women with symptomatic POP → can reduce symptoms (Grade A); uncertain if reduces POP stage (Grade B)
- Perioperative PFMT does not appear to improve symptoms or severity (Grade of Recommendation: B)

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Management of POP: physiotherapy/PFMT

- Improve pelvic floor muscle function, strength
- POPPY-trial *(n= 447) Hagen et al, Lancet 2014*
  - Individualised PFMT – effective in reducing prolapse symptoms at 12 months *(p = 0.0053)*
  - Tendency towards improvement in POPQ stage in intervention group at 6 months *(p= 0.10)*
  - Sexual/bladder/bowel function better at 6 months but not sustained at 12 months
  - Conclusion: 1:1 PFMT effective for improving symptoms in women with Stage 1-3 POP in the medium term

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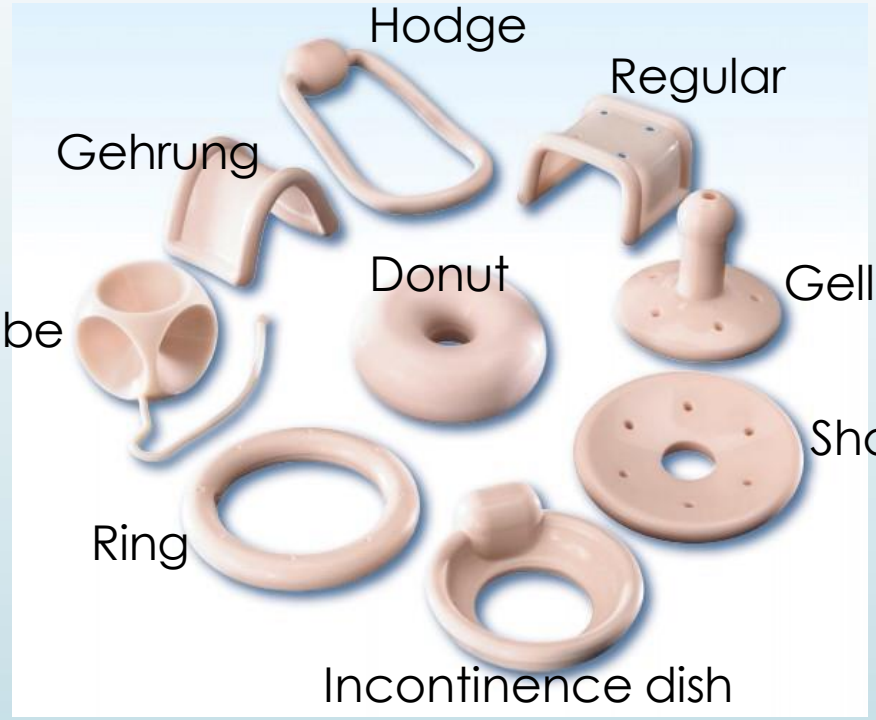
Management of POP: pessaries

- Inert, Non-allergenic, durable, autoclavable
- Non-absorption of vaginal secretions, odours
- Easy to remove and insert (generally)

Shelf



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Management of POP: pessaries

- **ICI 2023**
- No evidence to support routine pessary postpartum to prevent/improve POP (Grade B)
- Viable option for women with symptomatic POP (Grade B)
- Pessary and PFMT could both be recommended as treatment for POP – need to take into account cost and adverse events (Grade C)
- Combined pessary and PFMT recommended rather than PFMT alone (Grade B)

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Pessary fitting

- Fitting kit
- Vaginal length, width of introitus
- No guidelines or rules; usually trial and error
- Successful fitting rates 40-90%
  - 50% require >=2 visits
  - Median 2 pessaries tried
- Long term 30-35% treatment success at 5 years i.e., reduced POP symptoms, ongoing use

Types of pessaries

- **Support pessaries**
  - Ring pessaries (Portex, Hodge, Gehrung, Ring with support)
  - Held in place by levator tone
  - Better for milder stages of POP
- **Space-occupying pessaries**
  - Gellhorn, Cube, Donut, Inflatoball
  - Fills vagina
  - Useful in advanced POP, weak perineal body, wide genital hiatus
- **Incontinence pessaries** e.g., ring with knob (generally for management of SUI)

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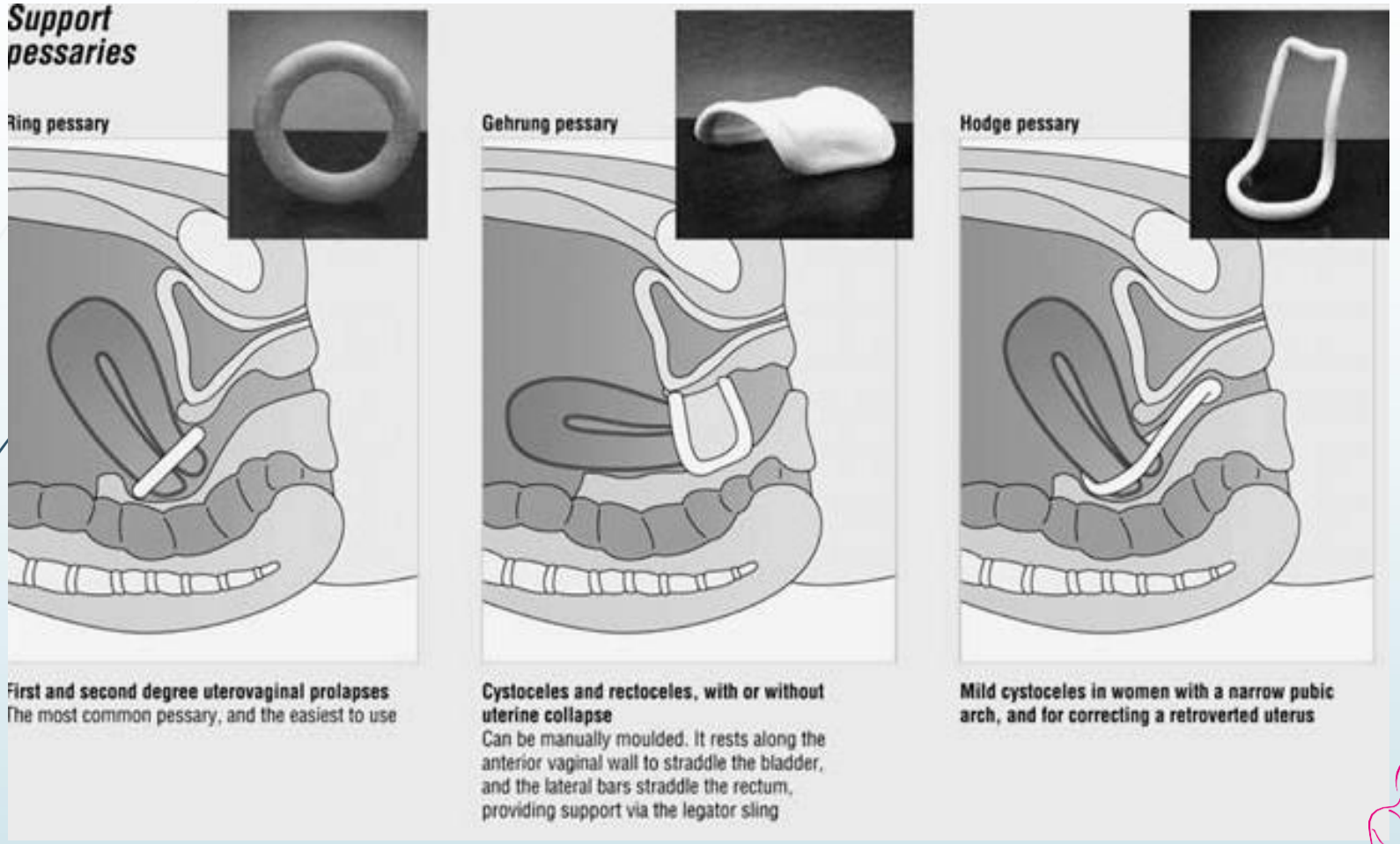
Types of pessary: support pessaries



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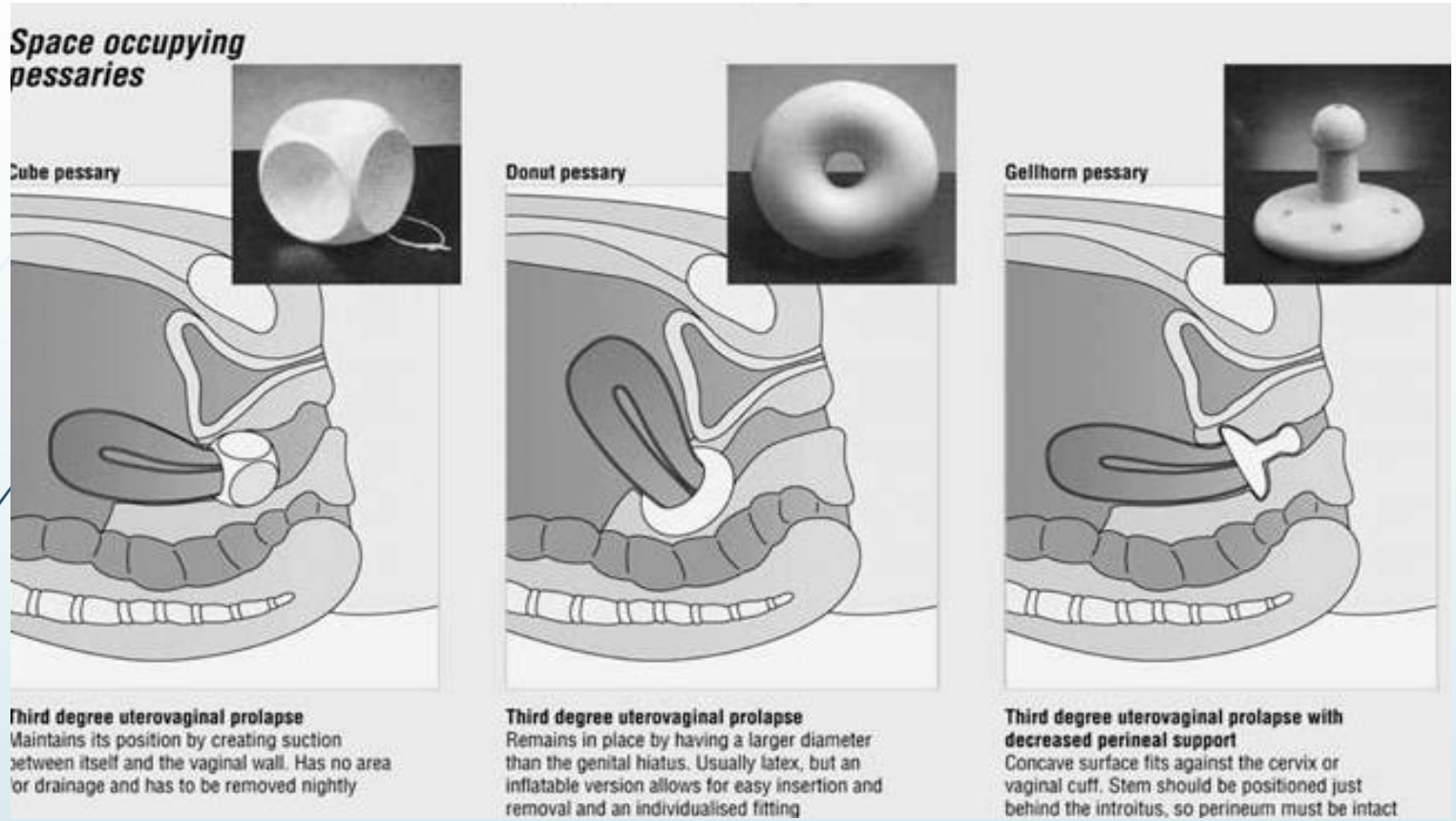
Types of pessary: space-occupying



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Which type of pessary for what type of prolapse?

- No evidence to guide choice

Fitting parameters	Types of pessary
Sexually active Not sexually active	• Ring ± support, Hodge pessary, Gehrung • Gellhorn, Shaatz, Donut, Cube, Shelf
Stage of prolapse II.- III III.- IV	• Ring ± support, Hodge pessary, • Gellhorn, Donut, Cube, Shelf,Inflatoball
Urinary incontinence & prolapse	• Incontinence dish ± support, Hodge pessary • Ring with support and knob

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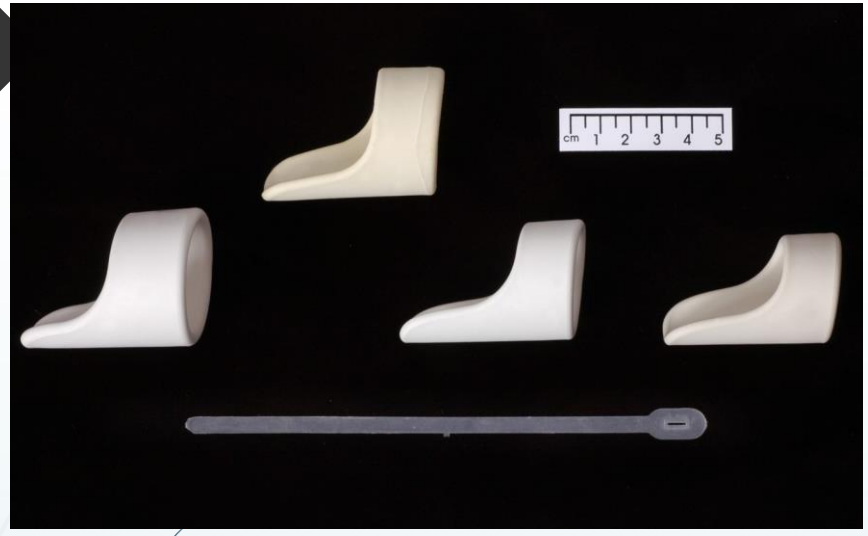
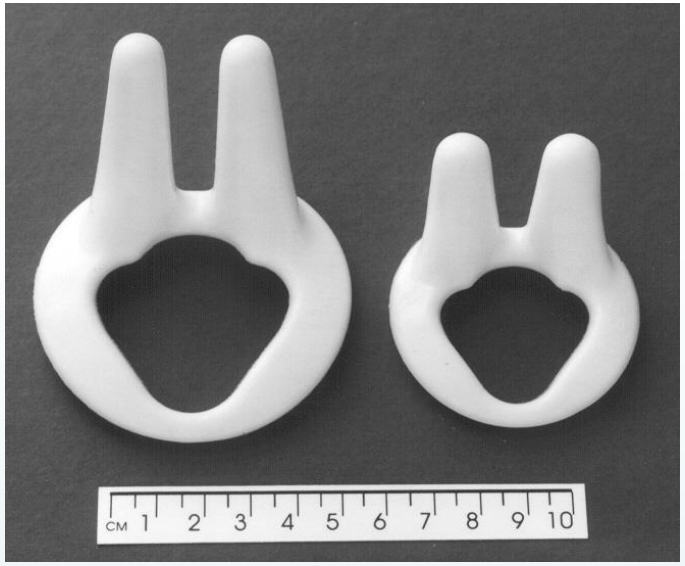
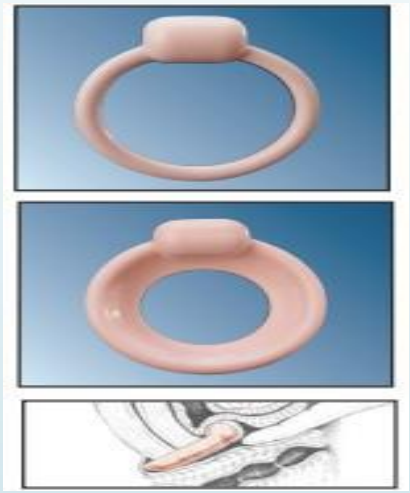
Pessaries for incontinence







- Contiform devices
- Ring with knob
- Dish with knob
- Generally, about 40-50% effectiveness
- ICI 2023: Grade B recommendation PFMT and continence pessary both effective in 1st line management of SUI

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TGA Classification of vaginal pessary devices

TGA Class 2A = short term use <= 30 days

TGA Class 2B = long term use > 30 days

Table 3. Commonly used TGA approved pessaries[39-43]

Pessary brand	Pessary type	Material	TGA listing details
TGA Class 2A pessaries (classified for use longer than 60mins but less than or equal 30 days continuously)			
Med Gyn	Ring, Ring with knob, Donut, Modified Cup, Donut, Modified Cup, Donut, Shaatz, Cube, Gellhorn short stem, Cup, Dish, Oval, Hodge, Marland, Gehrung	Silicone	ARTG ID: 368830 Manufacturer: MedGyn Products International Inc and MedGyn Products Inc Sponsor: Sigma Company Limited
Milex by Endotherapeutics	Ring, Ring with knob, Ring with support, Ring with knob & support, Incontinence ring, Hodge, Hodge with support, Hodge with knob, Hodge with knob & support, Risser Smith, Gehrung, Gehrung with knob	Silicone & metal	ARTG ID: 361771 Manufacturers: Cooper Surgical Inc T/a Ackrad Laboratories Prism Healthcare Milex Medscand Wallach Surg Dev SAGE In-Vitro Fertilization and Lone Star Medical Products Sponsor: Endotherapeutics Pty Ltd
Milex by Endotherapeutics	Shaatz, Donut regular, Gellhorn flexible, Incontinence dish, Incontinence dish with support, Cube, Tandem cube	Silicone	ARTG ID: 361771
Milex by Endotherapeutics	Inflatoball	Latex	ARTG ID: 361771
Wallace by Endotherapeutics	Ring pessary, Wallace	Flexible PVC	ARTG ID: 361771
Sayco	Incontinence ring, Hodge, Hodge with support	Silicone with inner metal component	ARTG ID: 399401 Manufacturer: Guangzhou Fame Medical Co Ltd Sponsor: Sayco Pty Ltd
Sayco	Ring with support, Ring without support, Gellhorn with drains soft 30mm/40mm stem, Gellhorn short stem 40mm, Donut, Marland with support, Marland no support, Oval support, Oval no support, Shaatz with drains, Ring with knob no support, Ring with knob support, Donut inflatable, Flexi shelf, Cup with support, Cup no support, Dish no support, Dish with support, Gehrung, Cube with drains, Cube no drains	Silicone	ARTG ID: 399401
Gynaecologic	CPOP, Ring	Silicone	ARTG ID 251215 Manufacturer: Surgi Supplies International Pty Ltd Sponsor: Gynaecologic Pty Ltd
TGA Class 2B pessaries (classified for continuous use longer than 30 days)			
Portia PVC ring by AMA medical products	Portia ring pessary	PVC	ARTG ID: 225317 Manufacturer: Bray Group Ltd Sponsor: AMA Services WA Pty/Ltd AMA Medical Products

Ref: Franks Z, Krause H. Australian and New Zealand Continence Journal 2023; 29(3):67-73

Pessary care

- Lack of evidence to guide optimal timing of follow up
- UK best practice document[1]
  - Review 4-6 weeks after initial fitting
  - 6 monthly after if self-managed successfully
- Options of self-care vs clinician-based pessary care
- '*Pessary holiday*' if abrasion/erosion found
  - Intravaginal estrogen
  - Salt baths ± antibiotics
  - Swab if foul-smelling discharge, biopsy if suspicious appearance
  - Consider changing size of pessary
- Use of vaginal estrogen cream – no evidence for harm or benefit (ICI 2023)

[1] United Kingdom Continence Society, Pelvic Obstetric and Gynaecological Physiotherapy. UK clinical guideline for best practice in the use of vaginal pessaries for pelvic organ prolapse; 2021.

Clinician-based vs self-care

- **Self-care**
  - patient removes and washes <= every 30 days prior to reinsertion
  - may see a clinician every 6-12 months for a speculum check

- **Clinician-led**
  - Not feasible to perform pessary check every 30 days or less (Class 2A)
  - 6 monthly (Class 2B)
  - generally regular review q3-6 months with speculum check/pessary removal

  - Important to inform patients and document that they are using it off-label if left in >30 days (Class 2A)
  - Evidence and guidelines suggest minimal and acceptable patient risk if in situ > 30 days

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Complications

- Vaginal discharge (30% pessary users vs 2% no pessary)
- Vaginal bleeding
- Erosion/abrasion
- Voiding dysfunction/obstructed defecation
- De novo SUI
- Discomfort
- Rare complications: Fistula; Bladder/bowel erosion; cervical entrapment;

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USE OF VAGINAL estrogen

- 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 2012*
    - Local estrogen treatment; RR 0.74 - ↓ voids/24hrs, frequency and urgency
  - Prolapse → *Cochrane 2010*
    - Limited evidence for the use of estrogen in prevention and management of POP
- Lowest dose to achieve benefit, review annually

Safety of vaginal estrogen use

- Observation studies show relative safety of local E2 therapy, lack of RCTs

Breast cancer, endometrial cancer, and cardiovascular events in participants who used vaginal estrogen in the Women's Health Initiative Observational Study

Crandall, Carolyn J. MD, MS; Hovey, Kathleen M. MS; Andrews, Christopher A. PhD; Chlebowski, Rowan T. MD, PhD; Stefanick, Marcia L. PhD; Lane, Dorothy S. MD, MPH; Shifren, Jan MD; Chen, Chu PhD; Kaunitz, Andrew M. MD; Cauley, Jane A. DrPH; Manson, JoAnn E. MD, DrPH

Author Information

Menopause 25(1):p 11-20, January 2018. | *DOI:* 10.1097/GME.0000000000000956

WHI 7.2 year follow up
No increase in breast cancer
N = 45 663

(RG) Obstetrics and Gynaecology

A cohort study of topical vaginal estrogen therapy in women previously treated for breast cancer

J. E. Dew, B. G. Wren & J. A. Eden

Pages 45-52 | Published online: 03 Jul 2009

N = 1472
5.5 year follow up
No increase in recurrent breast cancer

Climacteric 2003 Mar:6(1):45-52

Evidence for continued pessary use

- Continuation of use →
  - 66% of those who used pessary for > 1 month were still users at 1 year, 53% at 3 years *Wu et al, Obstet Gynecol 1997*
  - Of women who chose pessary to start with, 76% retained at 4 weeks after insertion. Over 5 years → 86% successfully continued to use over 5 years *Lone et al, IUGO 2011*
  - Longer term data shows : 61% of those who used pessary for 1 month, 14% continued use at 7 yrs *Sarma et al, BJOG 2009*

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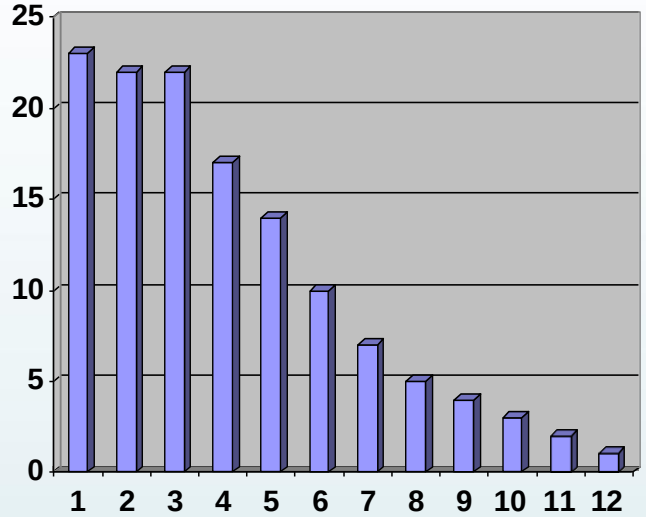
Long term use

- **Sarma et al, BJOG 2009**
  - N= 167 women fitted with ring pessary between 1992 – 2002, pts reviewed in Nov 2008
    - 61% continued use at 4 weeks
    - Of those who discontinued use, 30% chose surgery
    - 23 (14%) continued use of ring in 2008
    - Median duration of use 7 years (IQR 6 – 9)
  - Complications : Overall 56%
    - 40% had >1 type of complication; 31% > 1 episode of complication
    - Types of complications
      - Bleeding (47%); Expulsion (28%); Vaginal discharge (25%)
      - Pain/constipation (25%); Denovo incontinence (3%)
      - Removal in OT (1%)



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Predictors of success

- More likely to refuse pessary: Younger women; De novo SUI

- More likely to have fitting failure:
  - Previous hysterectomy
  - Widened genital hiatus
  - Short vaginal length
  - Rectocele
  - Larger gh:TVL ratio
  - Previous surgical failure

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Management of POP: surgical

- **Native tissue repair**

  Cystocoele – Anterior colporrhaphy
  Rectocoele – Posterior colporrhaphy
  Uterine prolapse – Hysterectomy (+ vault suspension) vs uterine-sparing
  Vault prolapse – Sacrospinous fixation / high uterosacral ligament suspension
  Colpocleisis

- **Synthetic mesh**
  - Transvaginal: No longer available in Australia except under SAS
  - Transabdominal: Sacrocolpopexy

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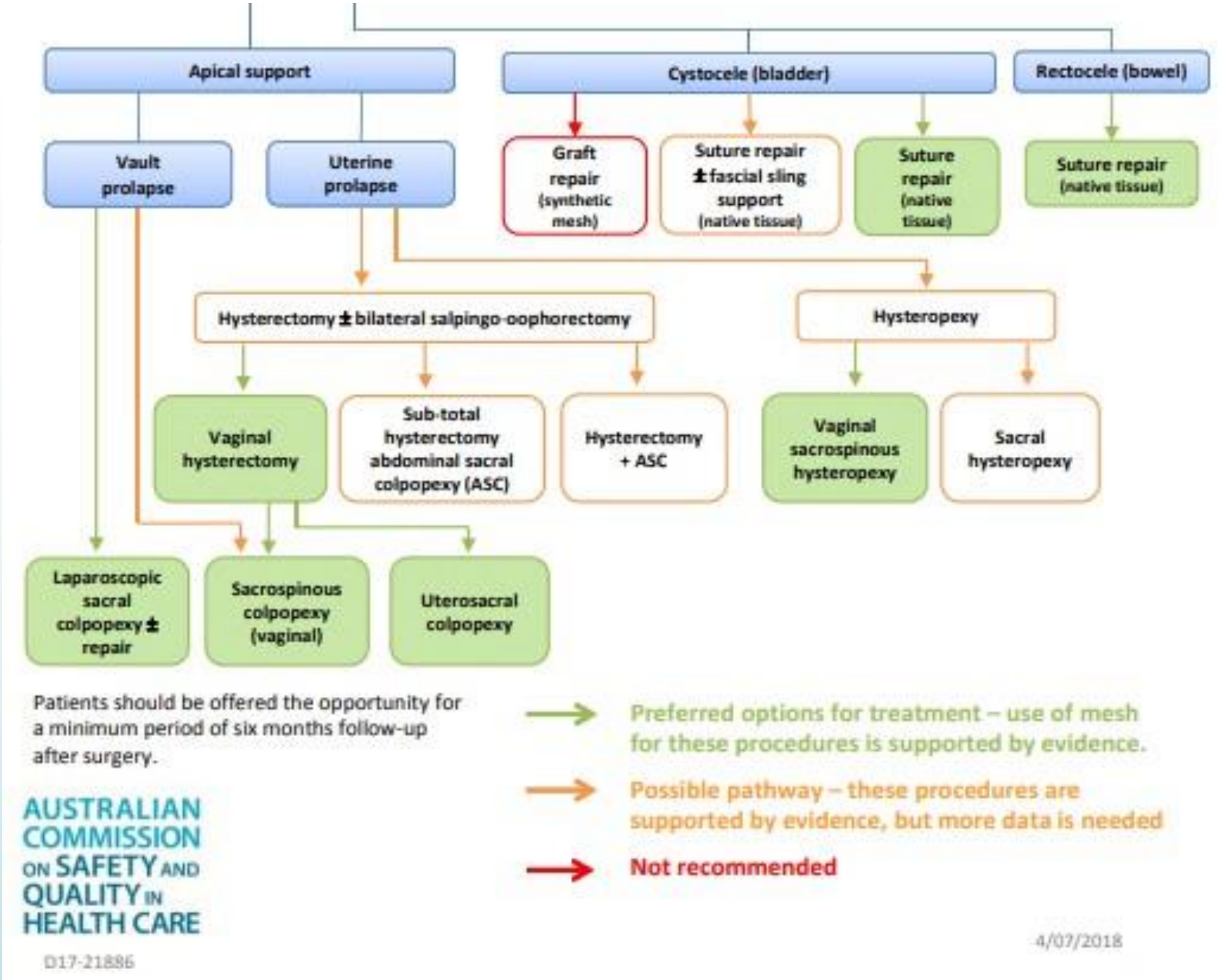
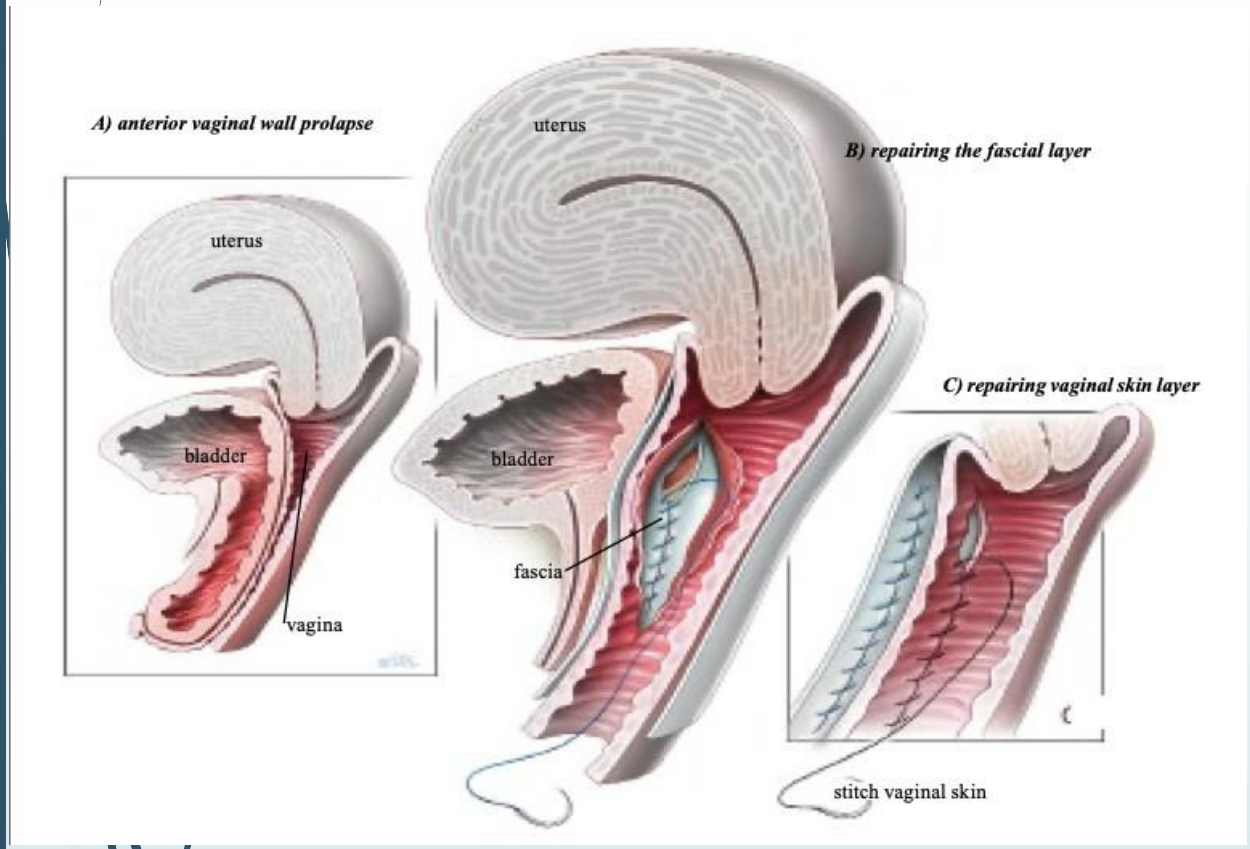
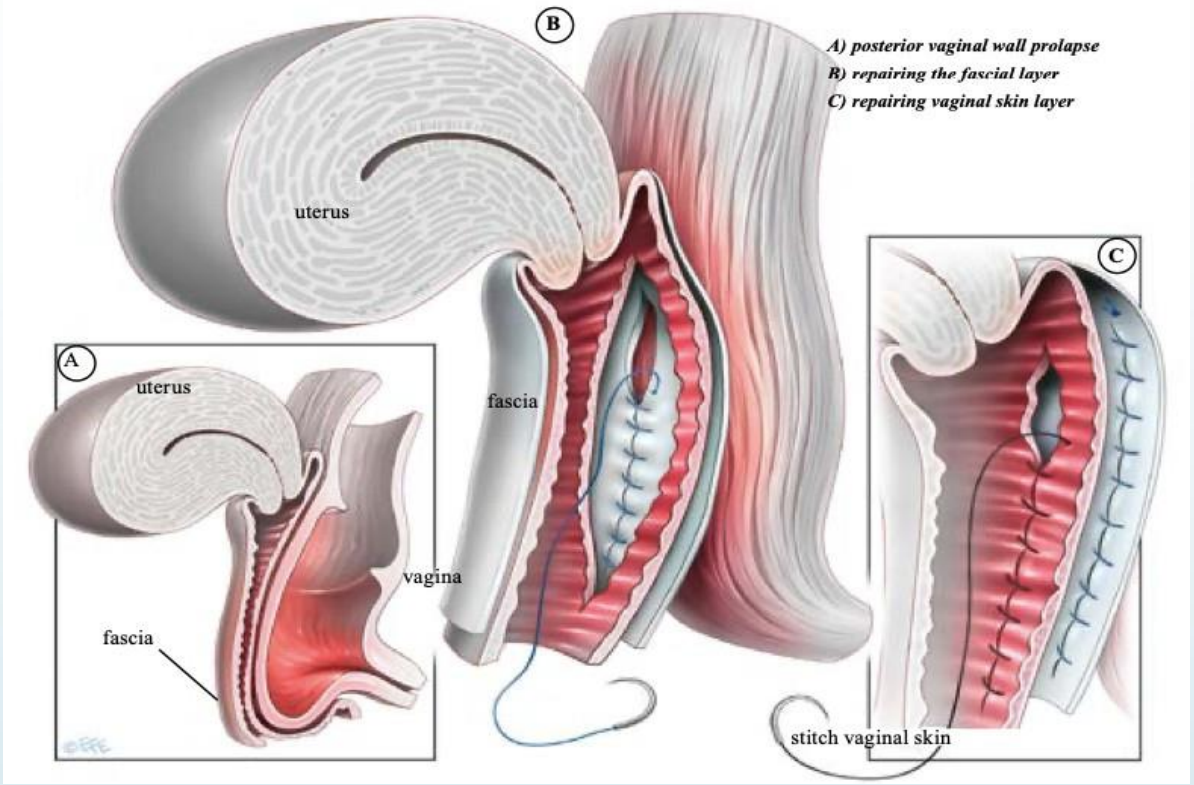

Apical support
Cystocele (bladder)
Rectocele (bowel)
Vault prolapse
Uterine prolapse
Graft repair (synthetic mesh)
Suture repair ± fascial sling support (native tissue)
Suture repair (native tissue)
Suture repair (native tissue)
Hysterectomy ± bilateral salpingo-oophorectomy
Hysteropexy
Vaginal hysterectomy
Sub-total hysterectomy abdominal sacral colpopexy (ASC)
Hysterectomy + ASC
Vaginal sacrospinous hysteropexy
Sacral hysteropexy
Laparoscopic sacral colpopexy ± repair
Sacrospinous colpopexy (vaginal)
Uterosacral colpopexy
Patients should be offered the opportunity for a minimum period of six months follow-up after surgery.
Preferred options for treatment – use of mesh for these procedures is supported by evidence.
Possible pathway – these procedures are supported by evidence, but more data is needed
Not recommended
AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE
D17-21886
4/07/2018

Anterior/posterior repair





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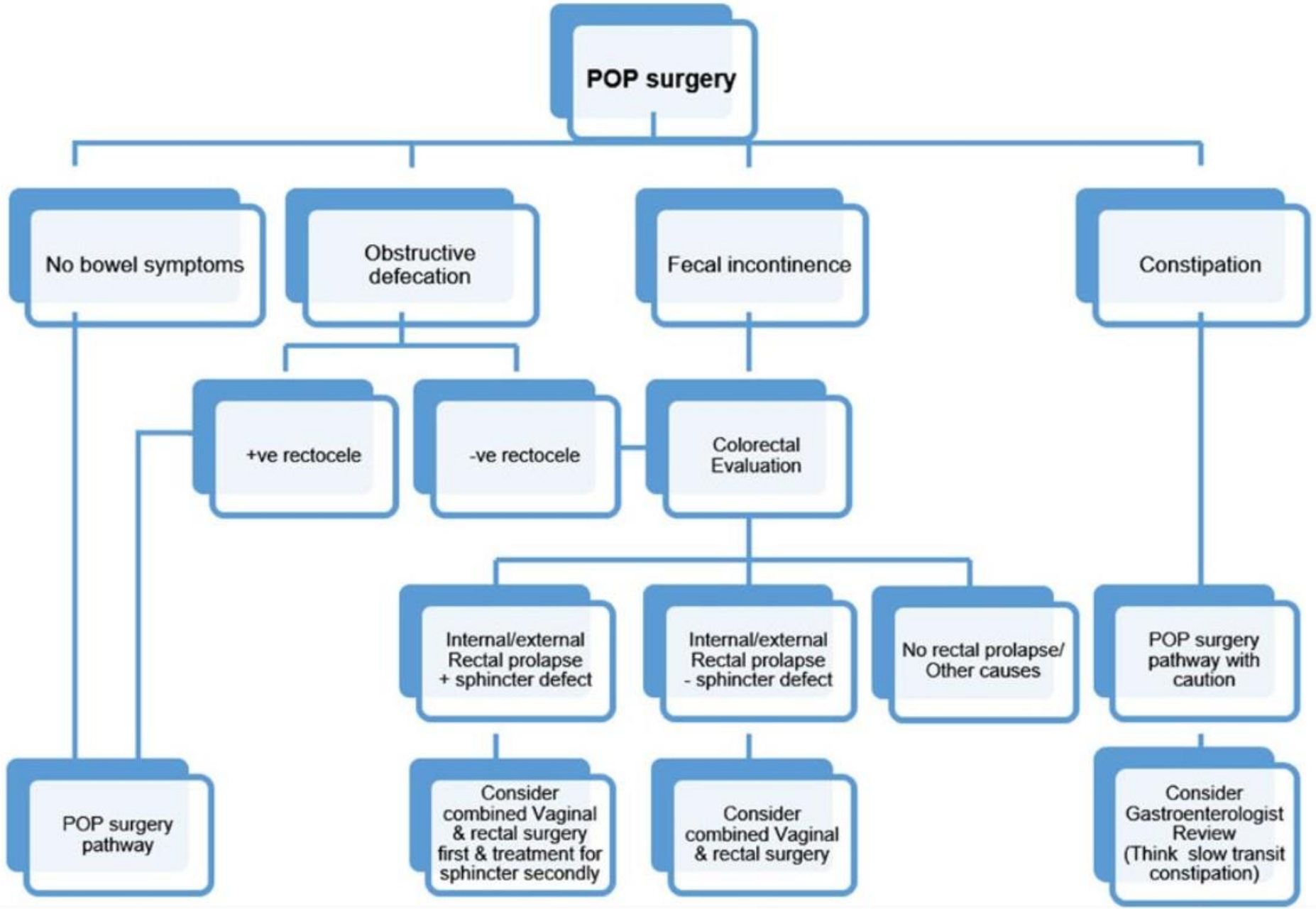
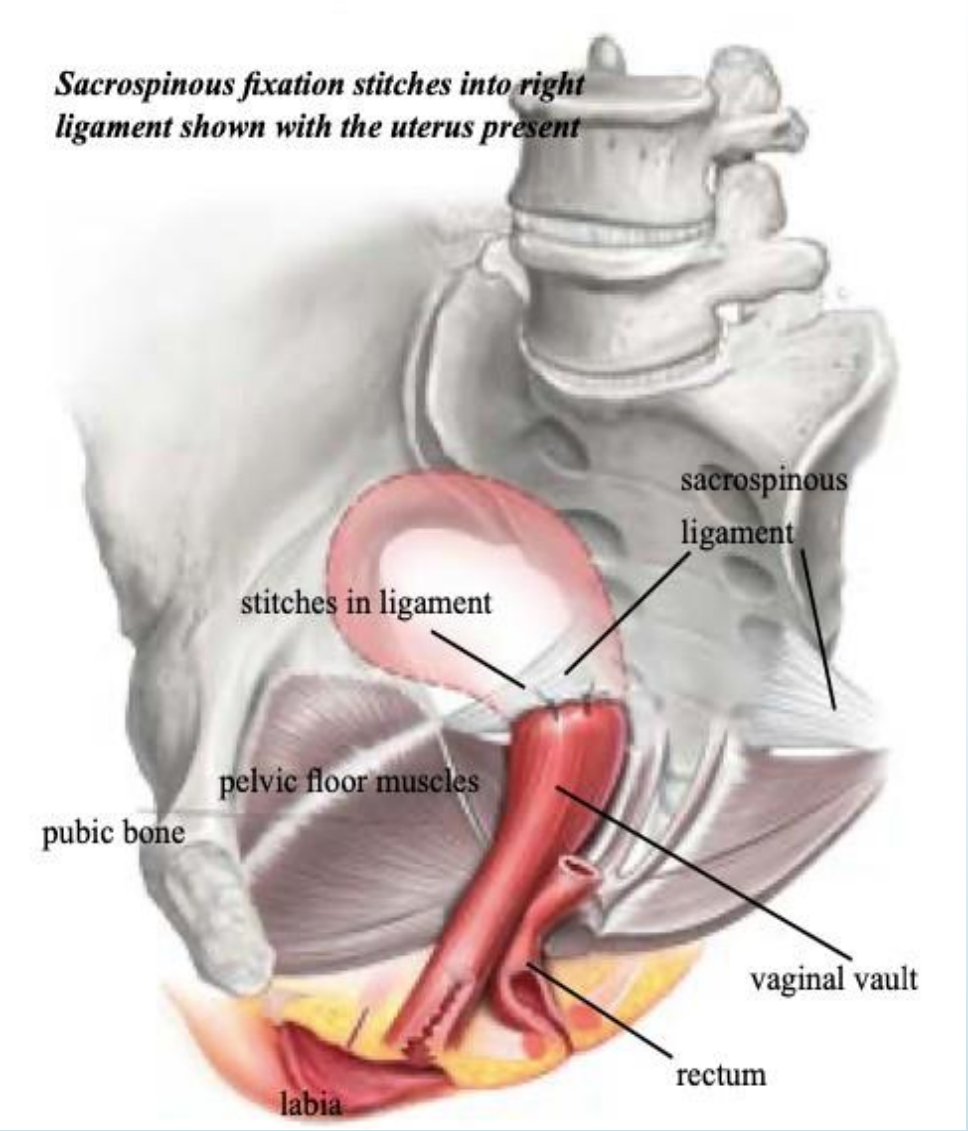
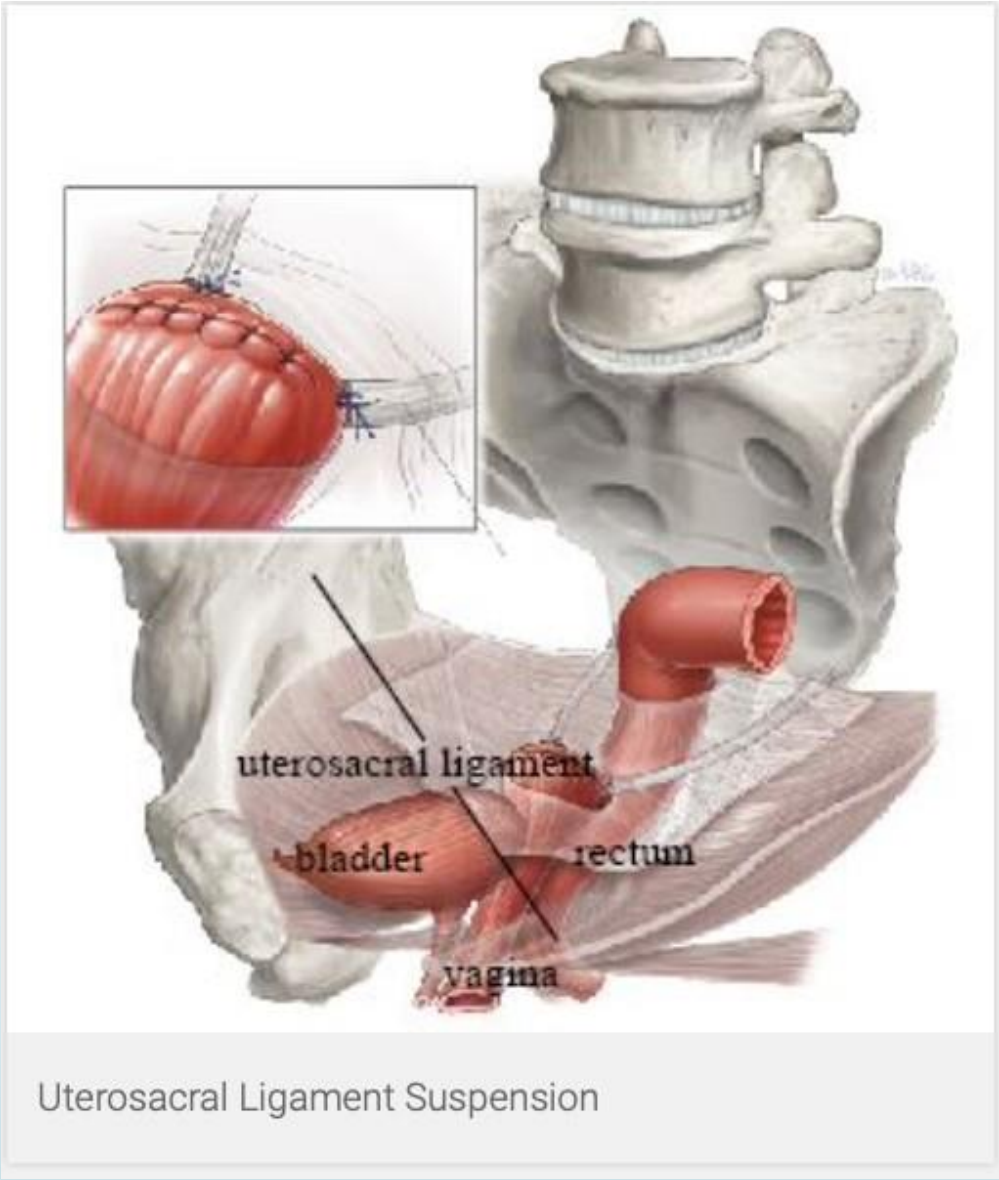


Figure 4. Prolapse surgery pathway and coexistent bowel symptoms.

Ref: ICI 2023

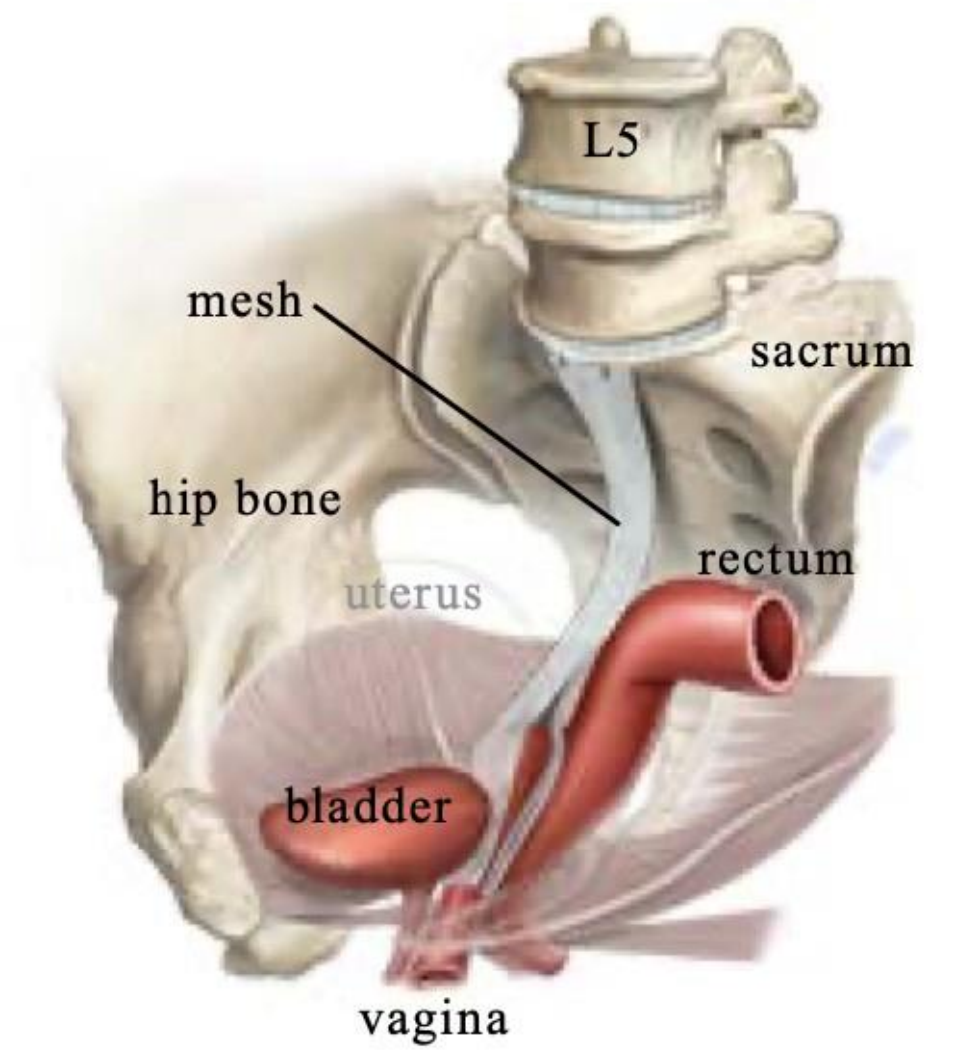
Apical - Sacrospinous fixation vs uterosacral ligament suspension





Uterosacral Ligament Suspension

Apical - sacrocolpopexy



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Complications

- Infection e.g. UTI, wound
- Bleeding, haematoma: 2% transfusion rate
- Visceral injury e.g. cystotomy, rectal, bowel
- *Ureteric injury – increased with ULS
- Neural injury: Gluteal pain up to 15% SSF; usually resolves by 6/52
- Dyspareunia
- De novo SUI
- Voiding dysfunction
- Recurrent POP/Failure

Sacrocolpopexy additional risks:

- **Mesh exposure/erosion 3.4% (sacrocolpopexy)**
- SBO/Ileus
- Incisional hernia repair 5%
- Rare: Sacral disciitis/osteomyelitis

Nygaard IE, McCreery R, Brubaker, L, Connolly AM, Cundiff G, Weber AM, Zyczynski H. Pelvic Floor Disorders Network. Abdominal Sacrocolpopexy: A Comprehensive Review, Obstetrics & Gynecology2004;104(4):805-823.

Evidence: vaginal apical procedures vs sacrocolpopexy

- **ICI 2023**
  - SCP ↓ awareness of POP, recurrent POP on examination, repeat surgery for POP, post op SUI/dyspareunia (Level 1)
  - SCP ↑ op time, inpatient stay, slower return to ADLs, cost (Grade A)

- Laparoscopic SCP ↓ EBL, op time, hospital stay c.f. abdominal (Grade B); no diff in subj/obj cure rate

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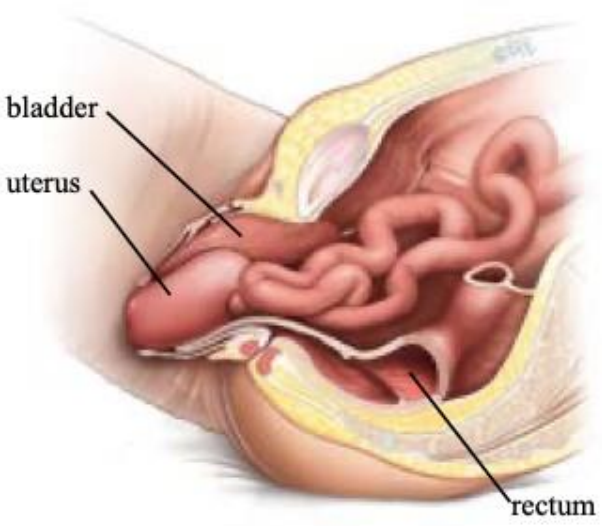
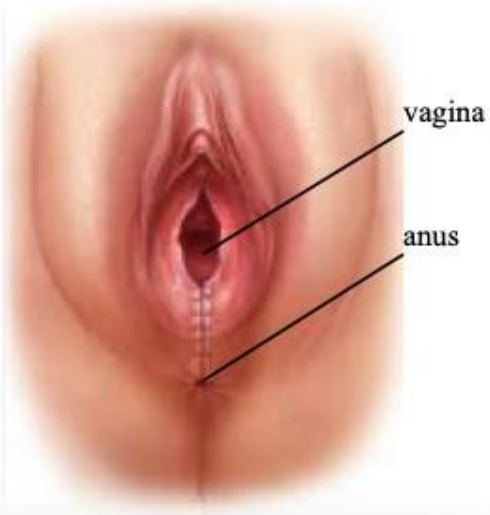
Colpocleisis

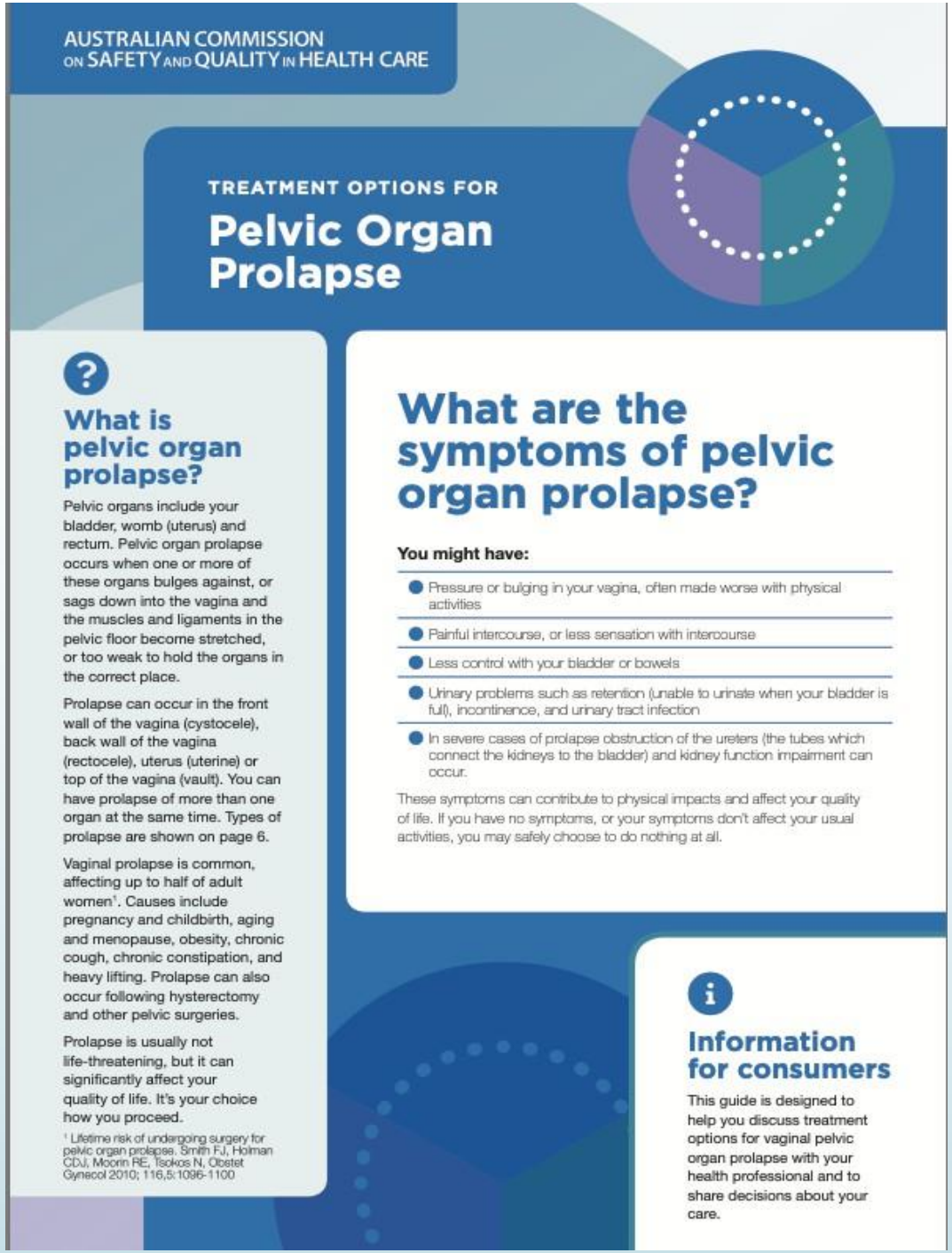
- Closure of vagina
- Suitable for frail elderly, no longer sexually active
- Regional/LA
- SR 2018: Shorter OR time vs VH/reconstructive surgery (Grade C)
- High cure rate >90%, low morbidity (Level 3)

Side view procidentia-before surgery



Appearance after colpocleisis surgery





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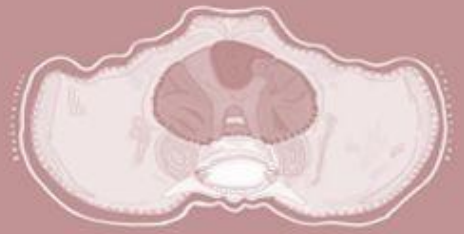
NEW

PELVIC FLOOR RECOVERY

PHYSIOTHERAPY FOR GYNAECOLOGICAL AND COLORECTAL REPAIR SURGERY

EDITION 5



SUE CROFT OAM
PHYSIOTHERAPIST

Foreword by PROFESSOR HANNAH KRAUSE AO

Pelvic Floor Exercise

"This is a comprehensive guide for women of all ages regarding pelvic floor function and advice. The publication of this 5th Edition is testament to the popularity of the book. I do advise women of all ages to read Sue's book 'Pelvic Floor Recovery' to improve their pelvic floor function and quality of life. The women I see with pelvic floor dysfunction who have read this book, have commented on its useful and practical information and guidance, including post-operative instructions. Many women have commented 'I have to ask my daughter to read this book'. Thank you Sue, for your dedication and for sharing your extensive knowledge with us all."

PROFESSOR JUDITH GOH AO
UROGYNAECOLOGIST

Many women undertake gynaecological and colorectal repair surgery including hysterectomy with some anxiety and trepidation. This guide has been written with the aim of reducing these fears by educating women about:

- Anatomy of the bladder and bowel.
- Correct activation of the pelvic floor muscles.
- Treatment of urinary incontinence.
- Fixing any bowel problems.
- Prolapse prevention and management.
- Bladder and bowel emptying positions.
- Persistent pain education.
- Pre-operative and post-operative physiotherapy strategies.
- Information to give confidence for the hospital stay.
- Post-op 'pelvic floor friendly' abdominal exercises.
- Post-op lifting advice.
- Advice to return to work, sport and travel with confidence.

pelvicfloorrecovery.com

Sue Croft OAM is a physiotherapist in private practice in Brisbane, Australia with a special interest in Pelvic Health Physiotherapy. Sue has worked in Women's, Men's and Children's pelvic health since 1988. Sue has written three books on pelvic health and is a passionate blogger on pelvic floor dysfunction. She actively encourages women to seek help from a pelvic health physiotherapist for any issues and promotes education for the bladder, bowel and pelvic floor through social media. Sue was awarded the Order of Australia Medal in 2023 for her services to community health as a physiotherapist.

ISBN 978-0-6452736-1-8

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Pelvic Floor Exercise

Key points

- First do no harm – if the patient has POP but is not symptomatic, do nothing
- Bowel and bladder symptoms not always due to POP
- Know how to perform and document a prolapse assessment
  - Speculum
  - POP-Q staging
- Conservative management is important
  - PFMT
  - Pessaries
- ACSQHC treatment options
- Be aware of surgical complications

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THANK YOU / LET'S CONNECT

yuhwee@qpfs.com.au

https://qpfs.com.au

Queensland Pelvic Floor Services

Greenslopes Private Hospital
Suite 209, Level 2
Ramsay Specialist Centre
Newdegate Street
Greenslopes QLD 4120

Phone (07) 3847 9939

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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

Metro South Health

Quality healthcare every day

Mixed Urinary Incontinence

Dr YuHwee Tan, Urogynaecologist MBCHB FRANZCOG CU

Queensland Pelvic Floor Services (Greenslopes Hospital)
Gold Coast HHS and the Queensland Pelvic Mesh Service

ICARE² values

Queensland Government

Purple Group Task

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Mixed urinary incontinence

DR YU HWEE TAN, MBCHB FRANZCOG CU
UROGYNAECOLOGIST

QUEENSLAND PELVIC FLOOR SERVICES, GREENSLOPES PRIVATE HOSPITAL
GOLD COAST HEALTH

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Conflicts of interest: Nil

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History

- **Bladder**
  - **Stress leakage**: cough/sneeze/intercourse
  - **Urge leakage**/urgency/frequency/nocturia
  - Hesitancy/slow voiding/incomplete emptying
  - Haematuria/bladder pain/recurrent UTIs
  - Bothersome scale/QOL
- **Bowel symptoms**
- **Prolapse symptoms**
- **Sexual function**

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History

- Fluid intake
- Past obstetric/gynae history
- Past med/surg history
- Medications

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RED FLAGS

REFER UROGYN/GYNAE/UROLOGY DEPENDING ON SYMPTOM

Taken from ACSQHC UI CARE pathway

Examination

- Supine: abdominal and pelvic
  - Speculum, BME
  - Left lateral
  - Angled table/chair (45°)
  - ?Standing

- Cough leak test
- Oxford grade: PFM strength
- +/- PR/neurological exam as indicated

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Risk Factors

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

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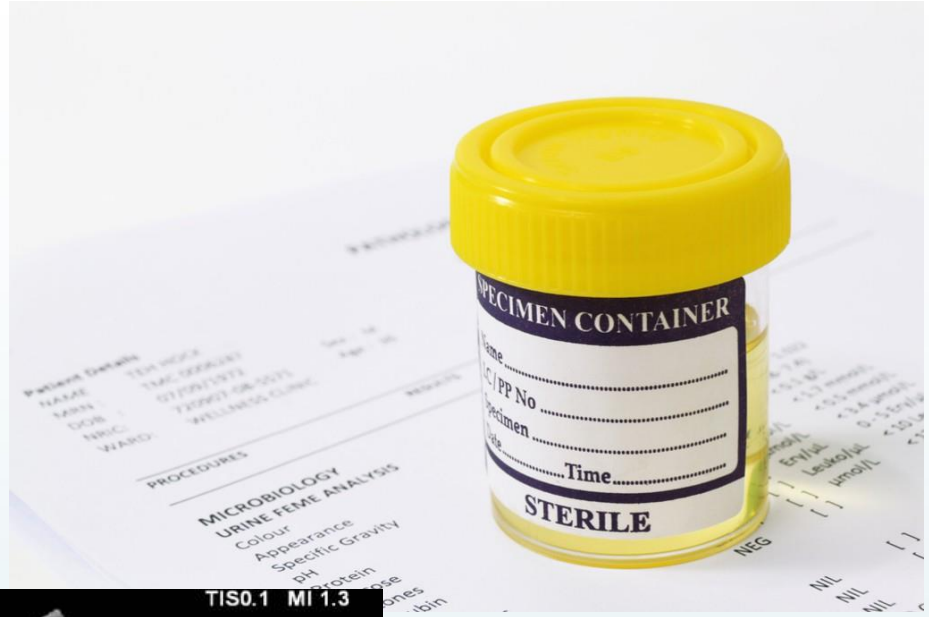
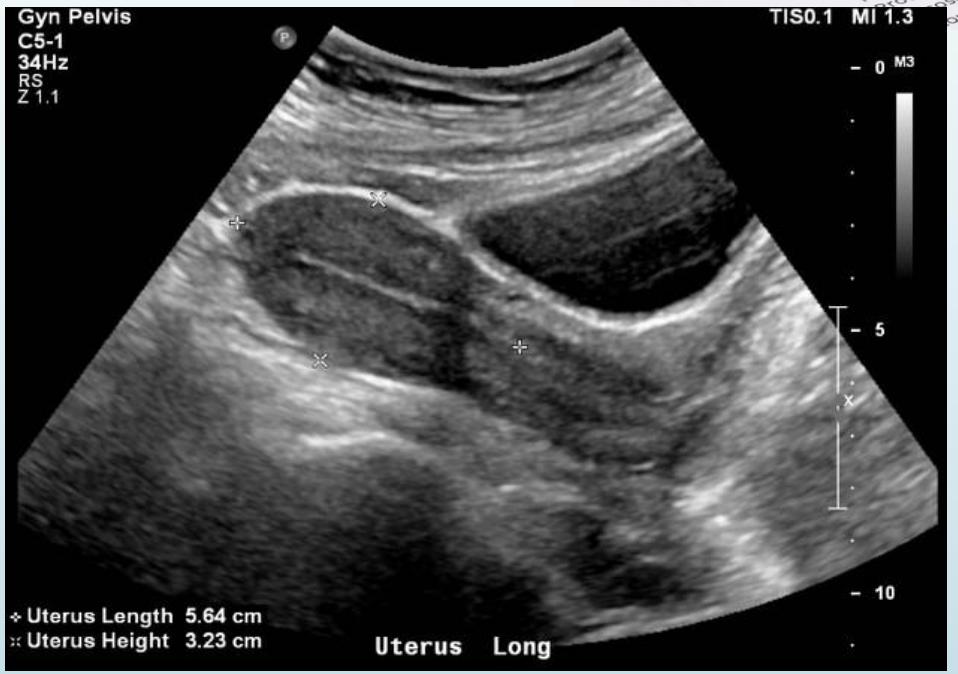
Investigations

- MSU for M/C/S
- ? Pelvic USS +/- renal tract US – PVR; masses
- Bladder diary
- Urodynamic studies





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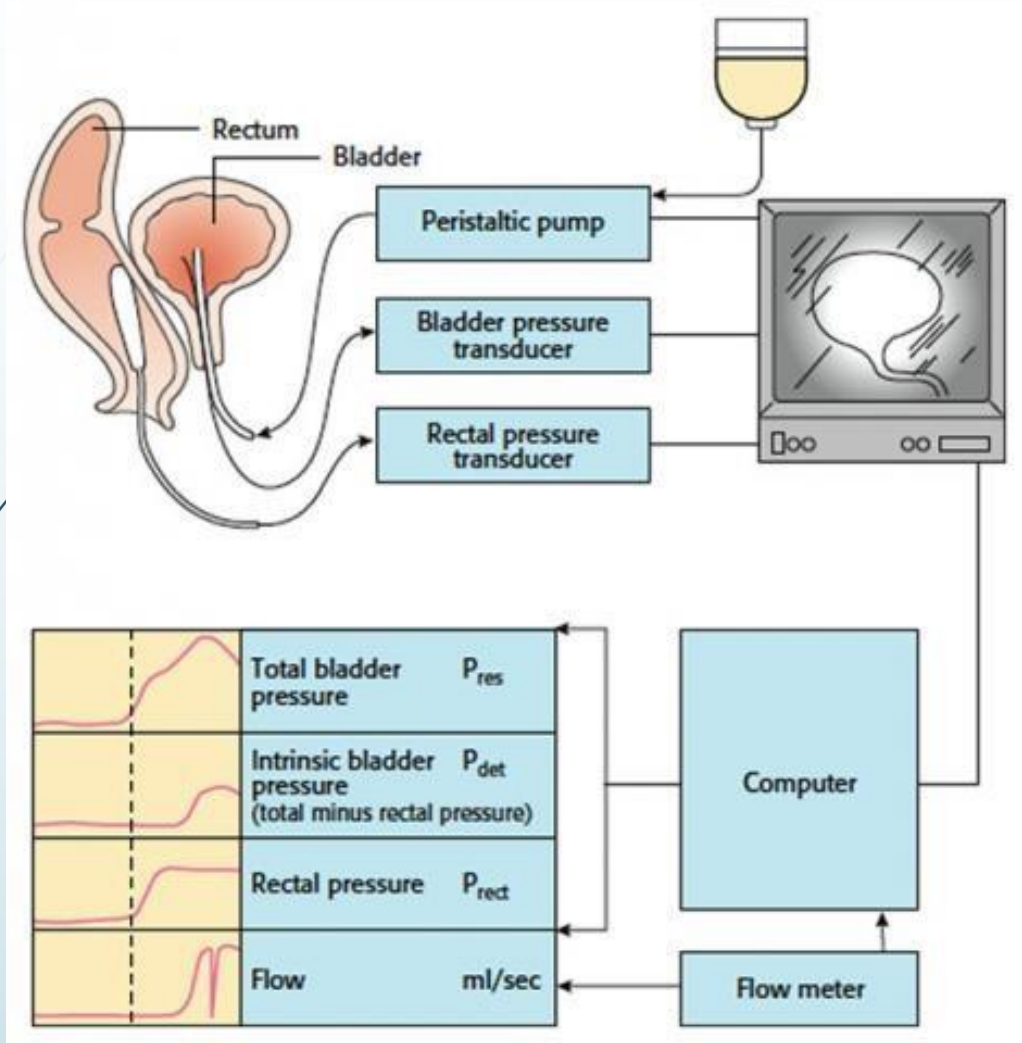
URODYNAMICS STUDIES



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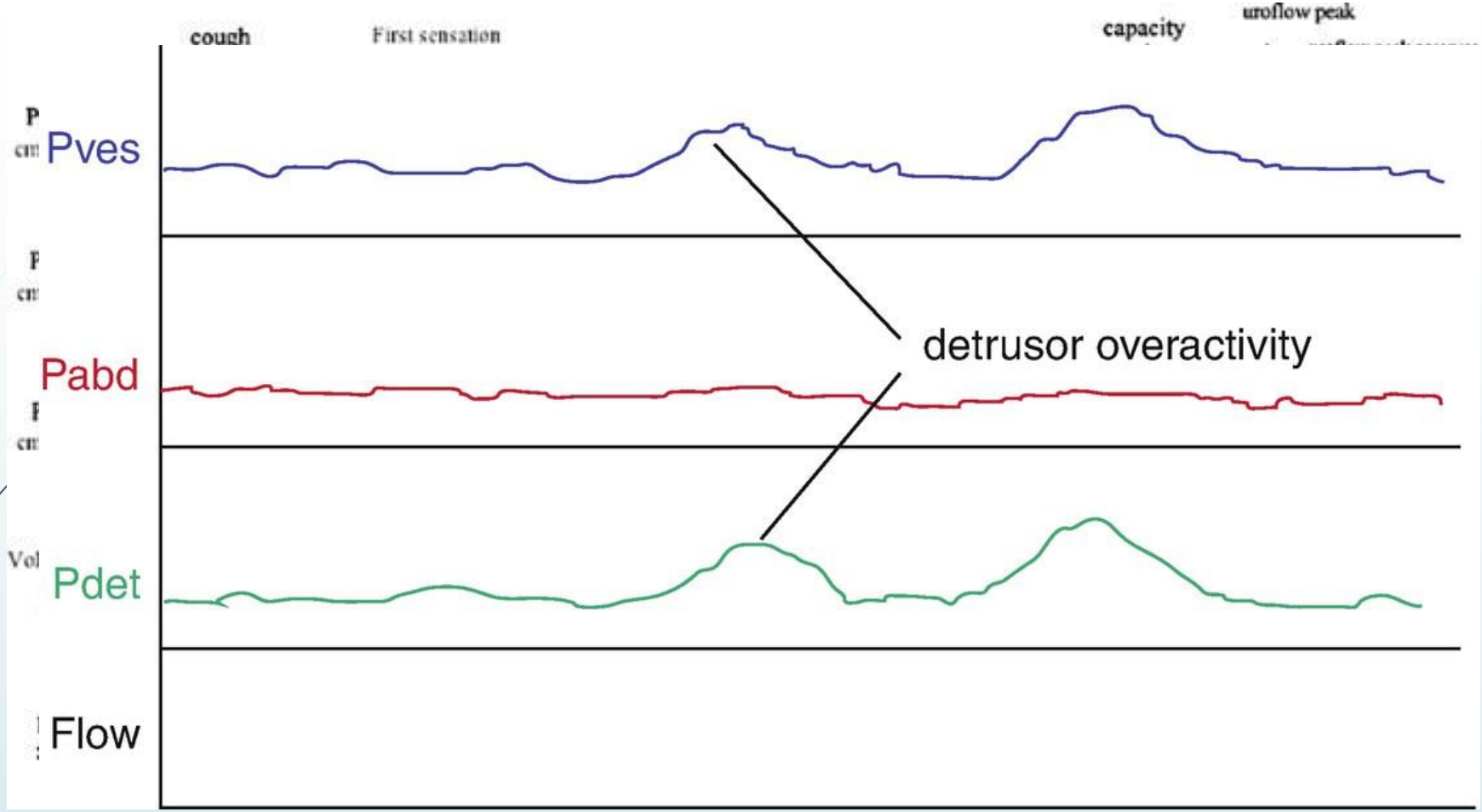

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Stress Incontinence

- ICS 2019: Complaint of involuntary loss of urine on effort or physical exertion e.g. sporting activities, or on sneezing or coughing.

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Overactive bladder symptoms

- **ICS 2019**
- **Urgency**
  - complaint of a sudden compelling desire to pass urine, which is difficult to defer
- **Urgency urinary incontinence**
  - complaint of involuntary leakage of urine from urethral orifice associated with urgency
- **Increased urinary frequency**
  - Complaint that voiding occurs more frequently during waking hours than deemed normal by individual
- **Nocturia**
  - the number of times urine is passed during the main sleep period

Mixed UI

- **ICS 2019**
  - Complaint of involuntary loss of urine associated with urgency and also with effort or physical exertion including sporting activities or on sneezing or coughing

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Management: Mixed UI

- Varies
- "Traditionalists"
  - Least invasive intervention
- "Purists"
  - Treat most bothersome urinary incontinence subtype i.e., presenting complaint
- "Interventionalists"
  - Surgery

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Management: OAB

- **Conservative**
  - Lifestyle changes
  - Bladder retraining/PFMT – pelvic floor physiotherapy
  - Vaginal estrogen
- **Medical**
  - Anticholinergics: Oxybutynin (oral/patch); Solifenacin (selective for M3 bladder receptors)
  - Mirabegron (activates β3 adrenergic receptor)
  - Intravesical Botox
- **Electrical stimulation**
  - Percutaneous tibial nerve stimulation (PTNS)
  - Sacral nerve stimulation (SNS)

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Management: SUI

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

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Conservative management: Mixed UI

- Little information in literature
- High quality evidence lacking for treating MUI
  - Suggest initial conservative management (Myers 2014)

- ICI (2023)
  - Initial conservative management with all subtypes of urinary incontinence
    - Weight reduction for overweight women (Grade A)
    - Avoid caffeine (Grade B)
    - Supervised PFMT (Grade A)
    - Pharmacological, topical oestrogen (Grade A/B)

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Evidence: Lifestyle

- **Cochrane 2015:**
  - Low quality evidence weight loss programs led to improvement in UI at 6 months(76% vs 54%, RR 1.4)
  - sustained at 18 months (75% vs 62%, no RR)

- **ICI 2023:**
  - Odds of developing UI at one year ↓ 3% for every kg lost by overweight/obese women (LOE 1)
  - Weight loss should be recommended to obese/overweight women with UI (GOR A)
  - Decreasing caffeine reduces UI (LOE 2, GOR B)
  - Chronic straining may be a RF for UI (LOE 3)

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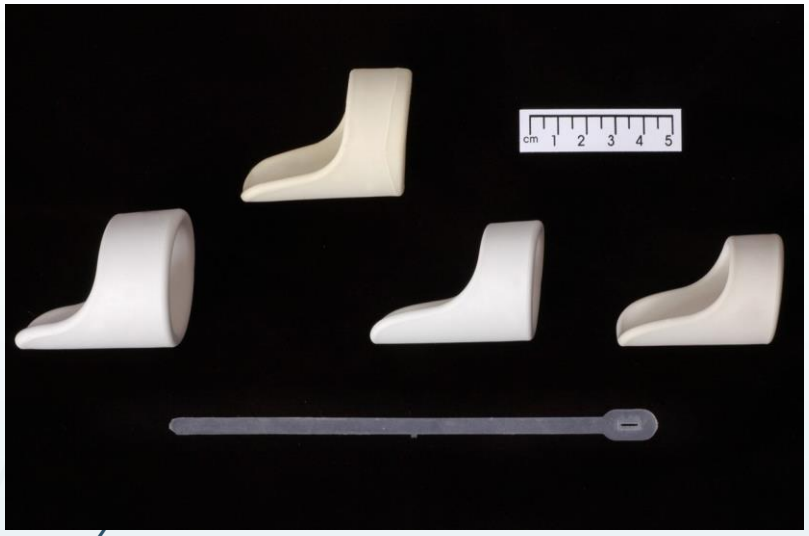
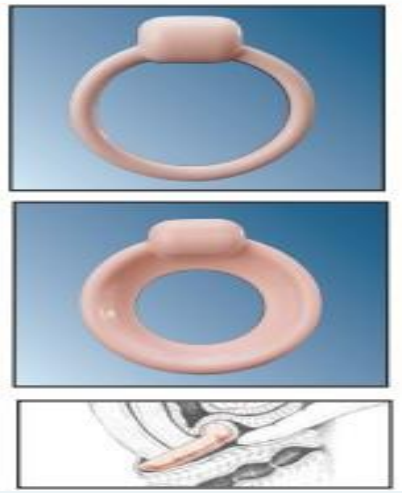
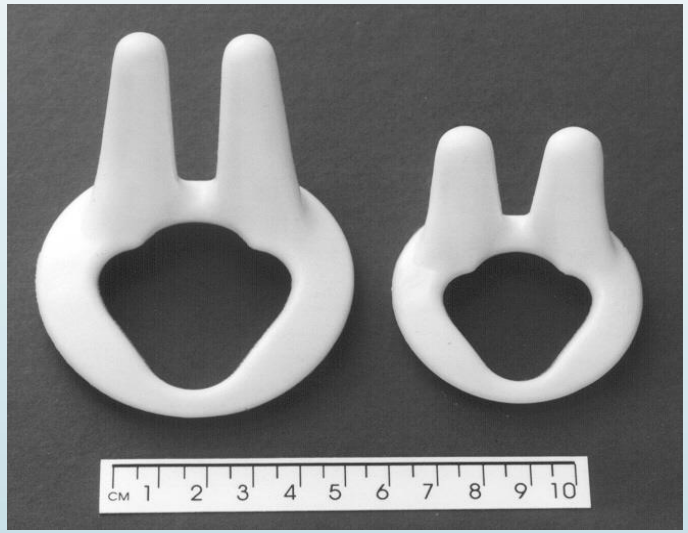
Evidence: Continence pessary







- Contiform devices
- Ring with knob
- Dish with knob
- Generally, about 40-50% effectiveness
- ICI 2023: Grade B recommendation PFMT and continence pessary both effective in 1st line management of SUI

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Evidence: Pelvic floor physiotherapy

- **Cochrane 2018**: PFMT vs no treatment
  - PFMT patients more likely to report cure (RR 8.4)
  - Increased cure of any type of UI (RR 5.3)

- **ICI 2023**: PFMT as treatment for women with UI:
  - PFMT effective as stand-alone therapy or in combination with other conservative measures (eg behavioural, lifestyle). (LOE 1)
  - Supervised PFMT should be offered as first-line tx for women of all ages with UI (GOR A)

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Medical management: Mixed UI

- Vaginal estrogen:
  - Conjoint USANZ/UGSA guideline 2016: Vaginal E2 should be offered to postmenopausal women with UI and vaginal atrophy (Level 1B evidence; Grade A recommendation)
  - SR Cardozo 2004: Vaginal estrogen may be beneficial in OAB symptoms
- Oral medications
- Intravesical Botox
- Limited evidence for medications in SUI

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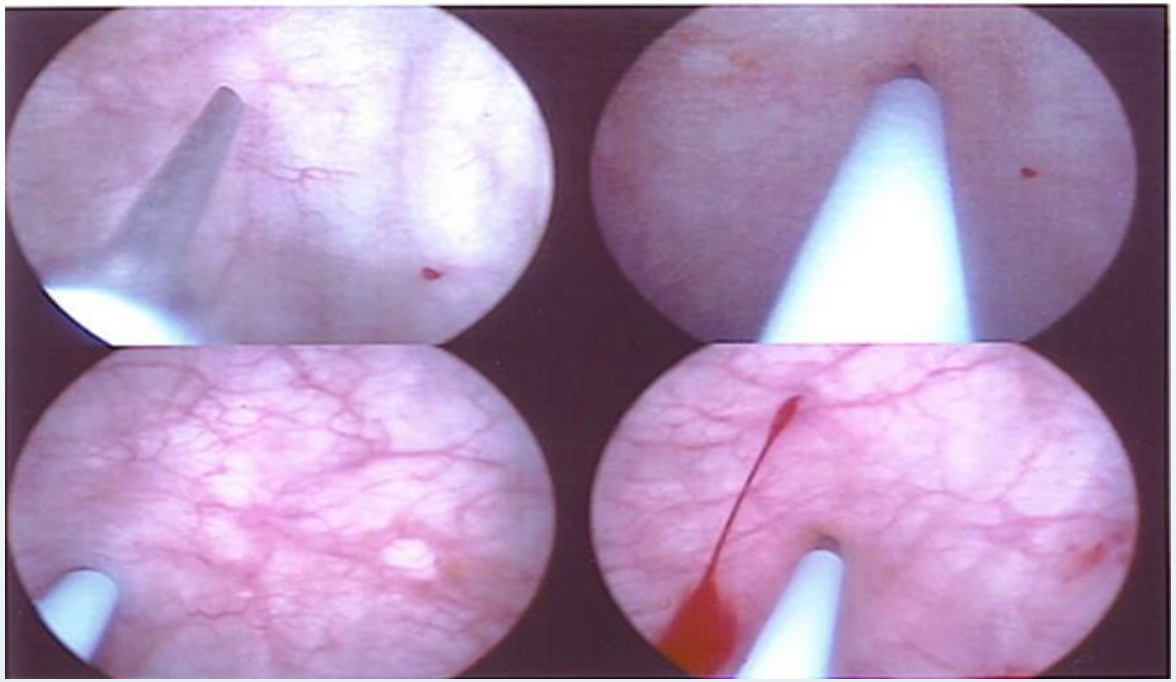
Medical management: OAB

Types of Medication	Level of Evidence	Grade of recommendation
Antimuscarinic drugs		
Oxybutynin IR (Ditropan)	1	A
Solifenacin (Vesicare)	1	A
Darifenacin (Enablex)	1	A
B3 adrenergic agonists		
Mirabegron (Betmiga)	1	A
Antidepressants		
Imipramine (Tofranil)	3	C
Toxins		
Botulinum toxin (neurogenic)	1	A
Botulinum toxin (idiopathic)	1	A

Table adapted from ICI 6th Report 2017

Botox

- Effective in approx. 70% of patients with OAB refractory to 1st line treatments
- Max dose: FDA recommends <360IU in a 3-month interval
- Adverse effects:
  - UTI 6-35%
  - Urinary retention 5-20%: ↑ risk older age, higher parity



Duthie JB, et al 2011 Botulinum toxin injections for adults with overactive bladder syndrome. Cochrane Database Syst Rev.
Uptodate - Use of Botulinum toxin for treatment of treatment of non-neurogenic lower urinary tract conditions
Miotla P et al 2017. Urinary retention in female OAB after intravesical Botox injection: who is really at risk? Int Urogynecol J. 2017;28(6):845. Epub 2016 Nov 26

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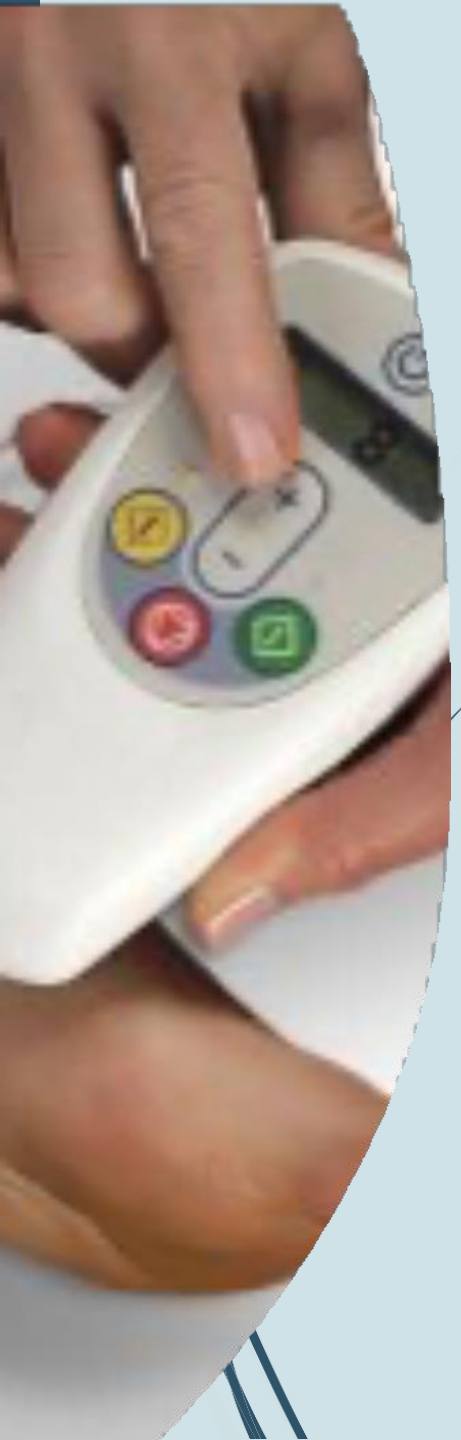
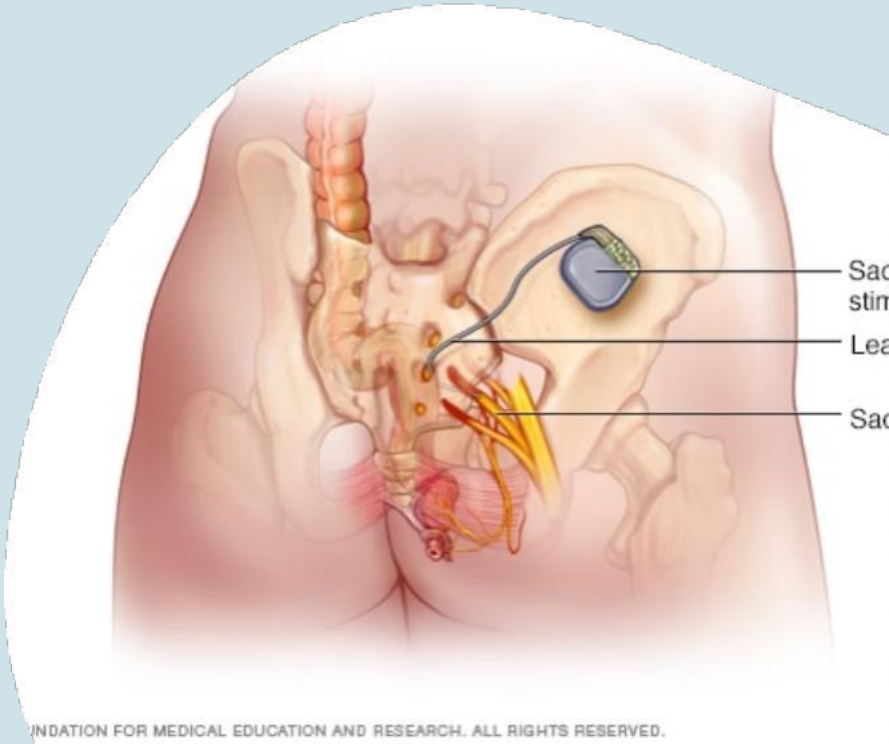


Electrical stimulation

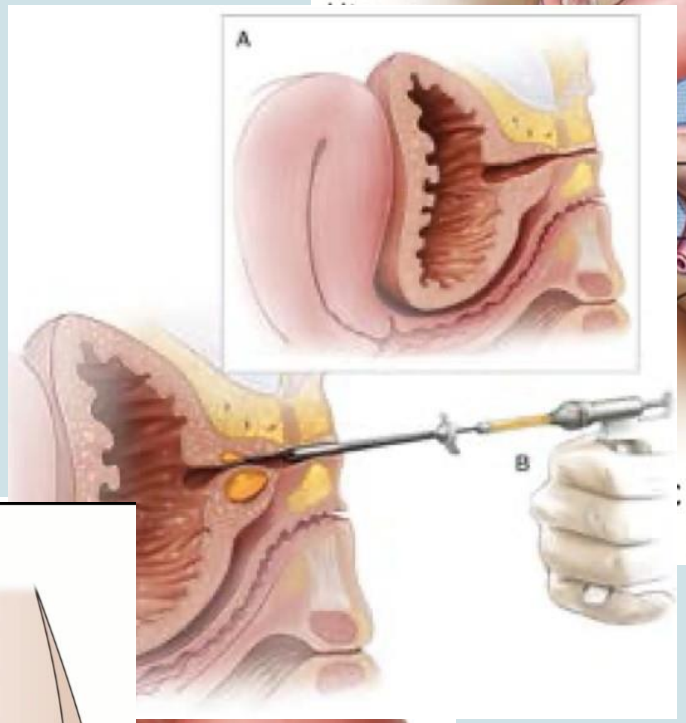
- **PTNS**
  - AUGS/SUFU guideline for non-neurogenic OAB: 3rd line treatment for refractory OAB
  - SUMIT: 55% mod/markedly improved PTNS vs 21 % sham group (12 weeks); effect sustained in 77% at 3 years
  - ICI 2023: PTNS is an effective therapy in selected pts with refractory OAB (GOR B)

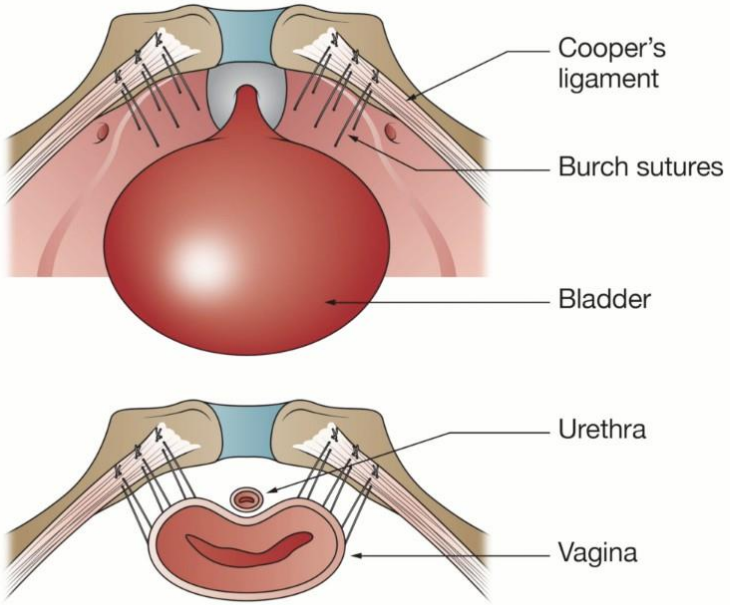
- **SNS**: Neuromodulation of pelvic nerves
  - AUGS/SUFU: 3rd line for refractory UUI
  - ICI 2023: SNS is an effective therapy for selected individuals with UF and UUI refractory to behavioural therapy and oral medications (GOR A)
  - Patients should be counselled regarding potential AEs, need for long term monitoring, interventions and additional surgeries to maintain effect (Gr A)

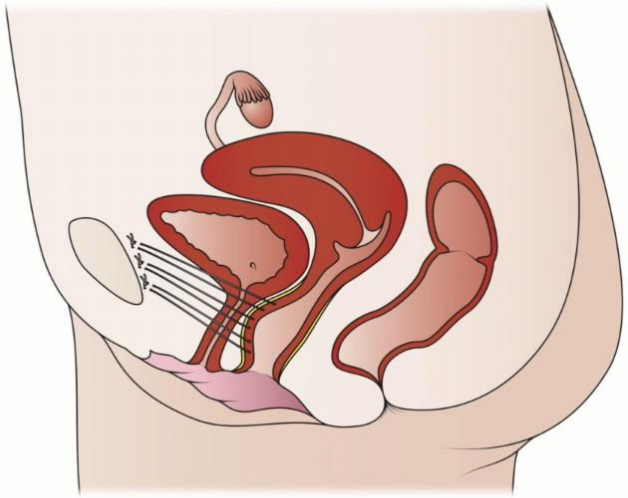


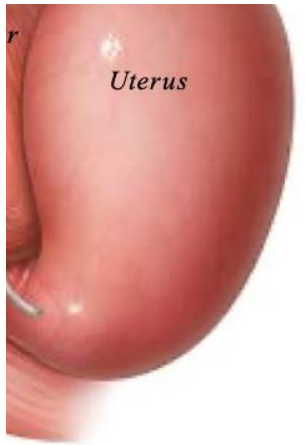
Surgical management

- Mainly for SUI
- Treatment options as per ACSQHC treatment options:
  - MUS (retropubic)
  - Pubovaginal sling
  - Colposuspension
  - Urethral bulking agents









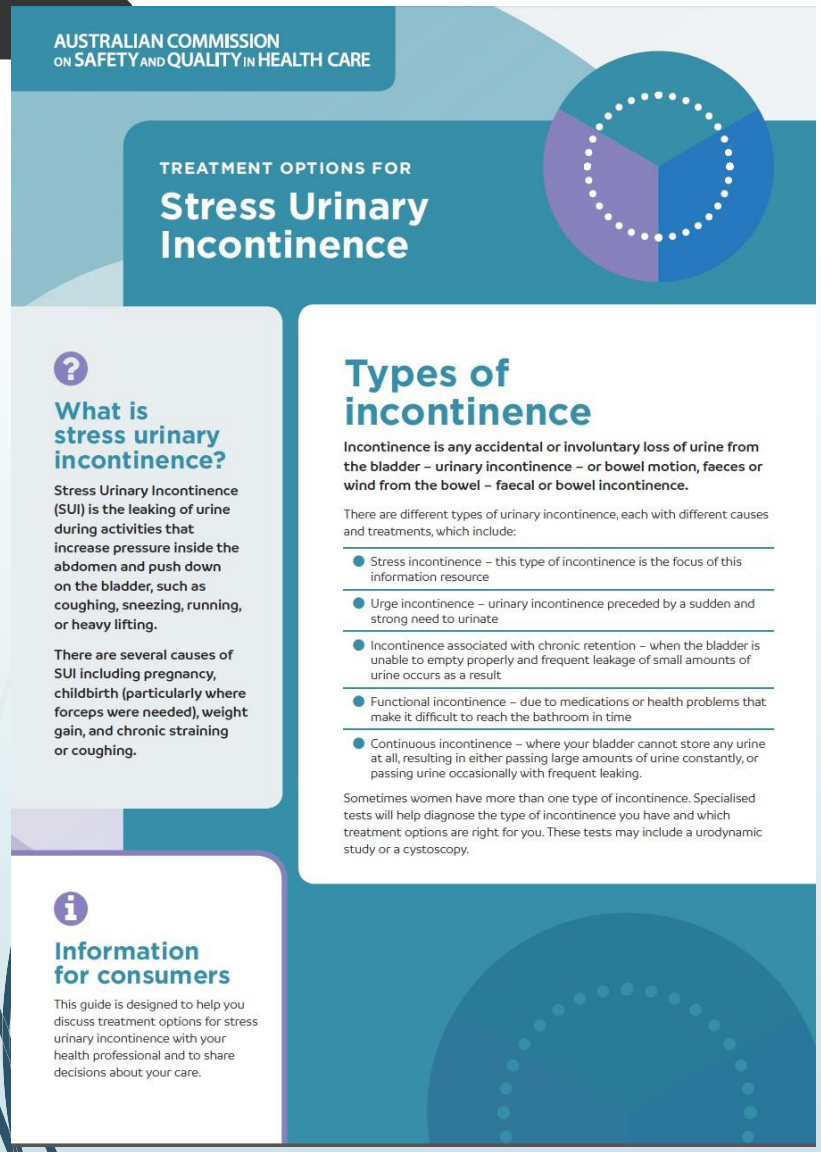
Queensland Pelvicfloorservices

Surgery for Mixed urinary incontinence: MUS

- OAB
  - Variable results – resolve, persist, worsen
    - Overall improvement in urgency UUI – 30-85% but in most studies, improvement decline with time (Jain et al 2011)
  - Urodynamics predictors for persisting UUI (Jain et al 2011, Lo et al 2020)
    - Low MUCP, low max flow rate
    - Low max cystometric capacity
    - Presence uninhibited detrusor contraction during filling, lower volume at detrusor contraction
- SUI
  - Success lower than in those with pure SUI (Holdo 2019)
    - 64 vs 84.5% - primary MUS at 35 months (Gleason et al 2015)
- Persisting overall incontinence after surgery
  - Menopause, age >60 years (Natale et al 2018)

Queensland Pelvicfloorservices

Management options: ACSQHC



AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

TREATMENT OPTIONS FOR

Stress Urinary Incontinence

What is stress urinary incontinence?

Stress Urinary Incontinence (SUI) is the leaking of urine during activities that increase pressure inside the abdomen and push down on the bladder, such as coughing, sneezing, running, or heavy lifting.

There are several causes of SUI including pregnancy, childbirth (particularly where forceps were needed), weight gain, and chronic straining or coughing.

Information for consumers

This guide is designed to help you discuss treatment options for stress urinary incontinence with your health professional and to share decisions about your care.

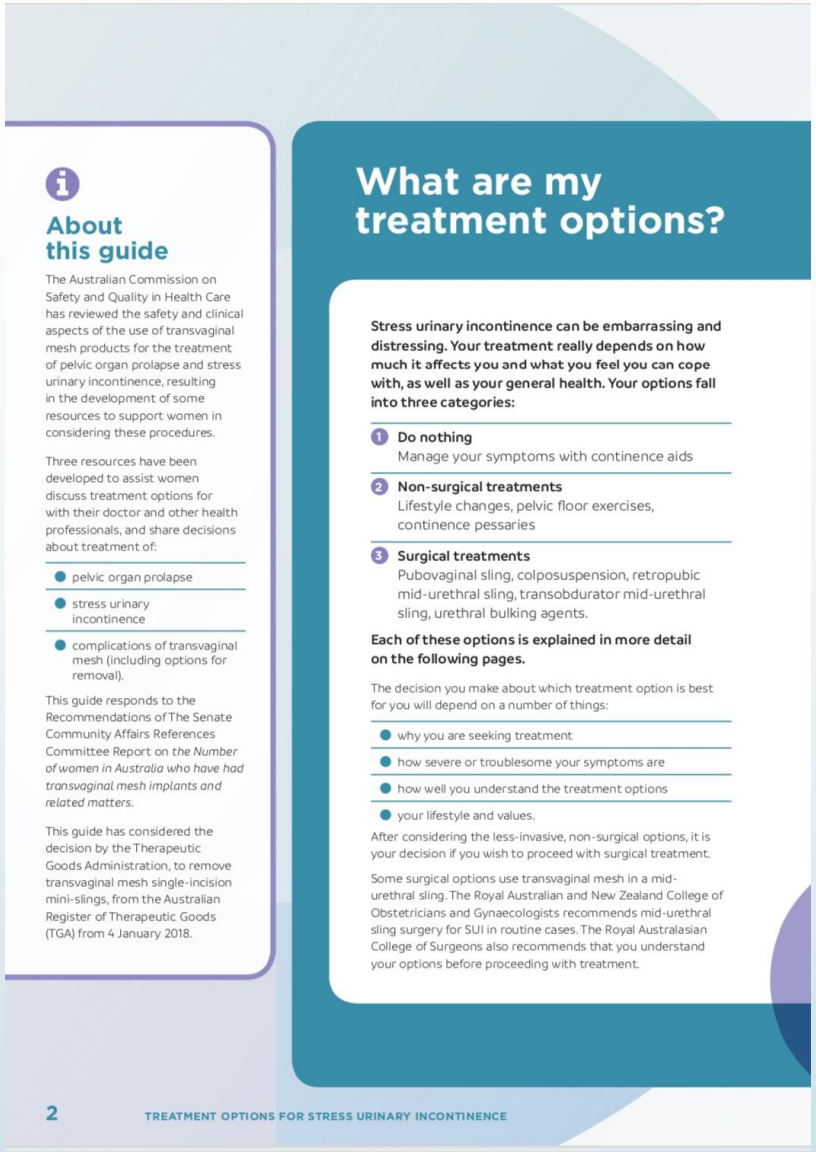
Types of incontinence

Incontinence is any accidental or involuntary loss of urine from the bladder – urinary incontinence – or bowel motion, faeces or wind from the bowel – faecal or bowel incontinence.

There are different types of urinary incontinence, each with different causes and treatments, which include:

- Stress incontinence – this type of incontinence is the focus of this information resource
- Urge incontinence – urinary incontinence preceded by a sudden and strong need to urinate
- Incontinence associated with chronic retention – when the bladder is unable to empty properly and frequent leakage of small amounts of urine occurs as a result
- Functional incontinence – due to medications or health problems that make it difficult to reach the bathroom in time
- Continuous incontinence – where your bladder cannot store any urine at all, resulting in either passing large amounts of urine constantly, or passing urine occasionally with frequent leaking.

Sometimes women have more than one type of incontinence. Specialised tests will help diagnose the type of incontinence you have and which treatment options are right for you. These tests may include a urodynamic study or a cystoscopy.



About this guide

The Australian Commission on Safety and Quality in Health Care has reviewed the safety and clinical aspects of the use of transvaginal mesh products for the treatment of pelvic organ prolapse and stress urinary incontinence, resulting in the development of some resources to support women in considering these procedures.

Three resources have been developed to assist women discuss treatment options for with their doctor and other health professionals, and share decisions about treatment of:

- pelvic organ prolapse
- stress urinary incontinence
- complications of transvaginal mesh (including options for removal).

This guide responds to the Recommendations of The Senate Community Affairs References Committee Report on *the Number of women in Australia who have had transvaginal mesh implants and related matters.*

This guide has considered the decision by the Therapeutic Goods Administration, to remove transvaginal mesh single-incision mini-slings, from the Australian Register of Therapeutic Goods (TGA) from 4 January 2018.

What are my treatment options?

Stress urinary incontinence can be embarrassing and distressing. Your treatment really depends on how much it affects you and what you feel you can cope with, as well as your general health. Your options fall into three categories:

1. **Do nothing**
   Manage your symptoms with continence aids
2. **Non-surgical treatments**
   Lifestyle changes, pelvic floor exercises, continence pessaries
3. **Surgical treatments**
   Pubovaginal sling, colposuspension, retropubic mid-urethral sling, transobdurator mid-urethral sling, urethral bulking agents.

Each of these options is explained in more detail on the following pages.

The decision you make about which treatment option is best for you will depend on a number of things:

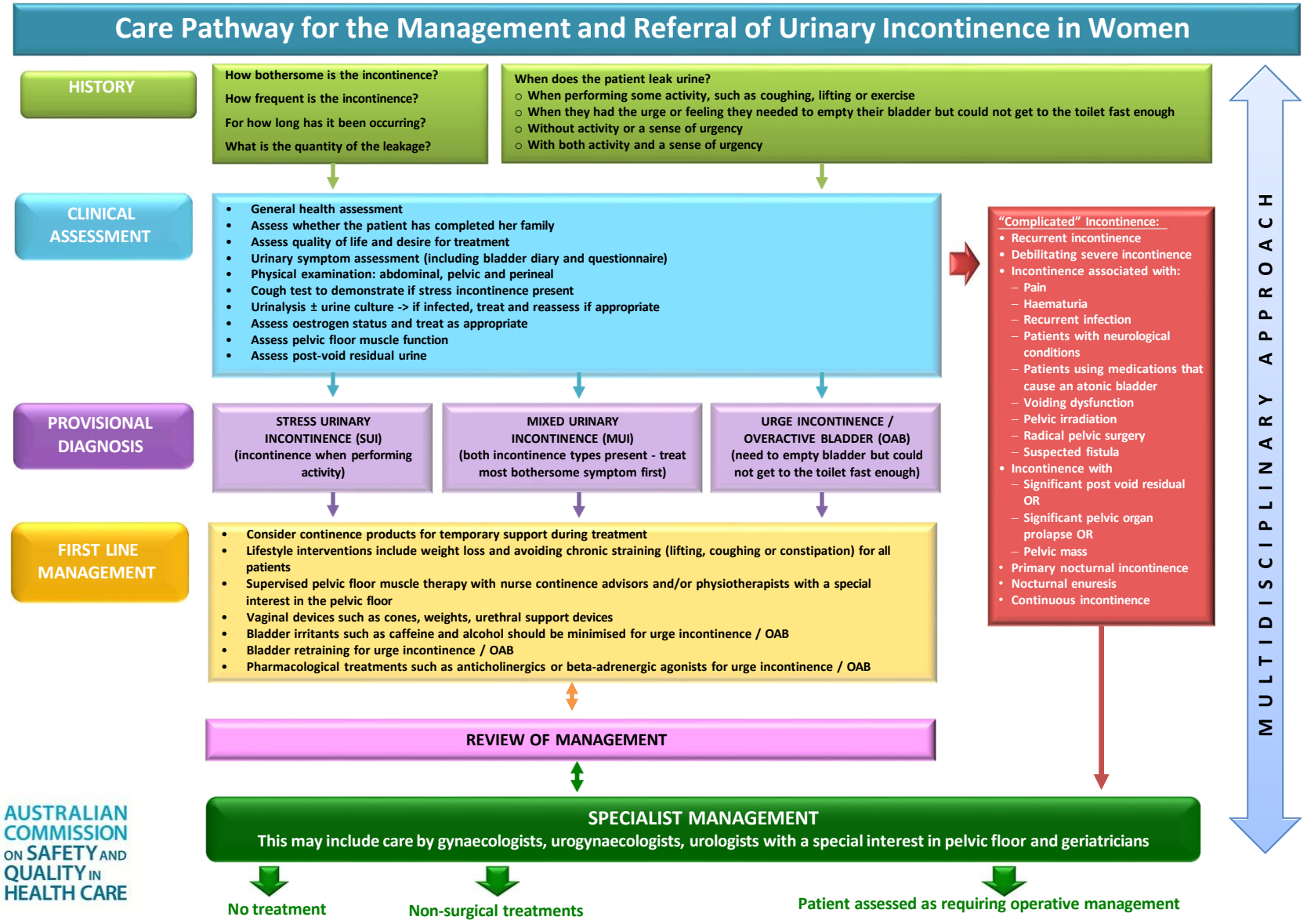
- why you are seeking treatment
- how severe or troublesome your symptoms are
- how well you understand the treatment options
- your lifestyle and values.

After considering the less-invasive, non-surgical options, it is your decision if you wish to proceed with surgical treatment.

Some surgical options use transvaginal mesh in a mid-urethral sling. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists recommends mid-urethral sling surgery for SUI in routine cases. The Royal Australasian College of Surgeons also recommends that you understand your options before proceeding with treatment.

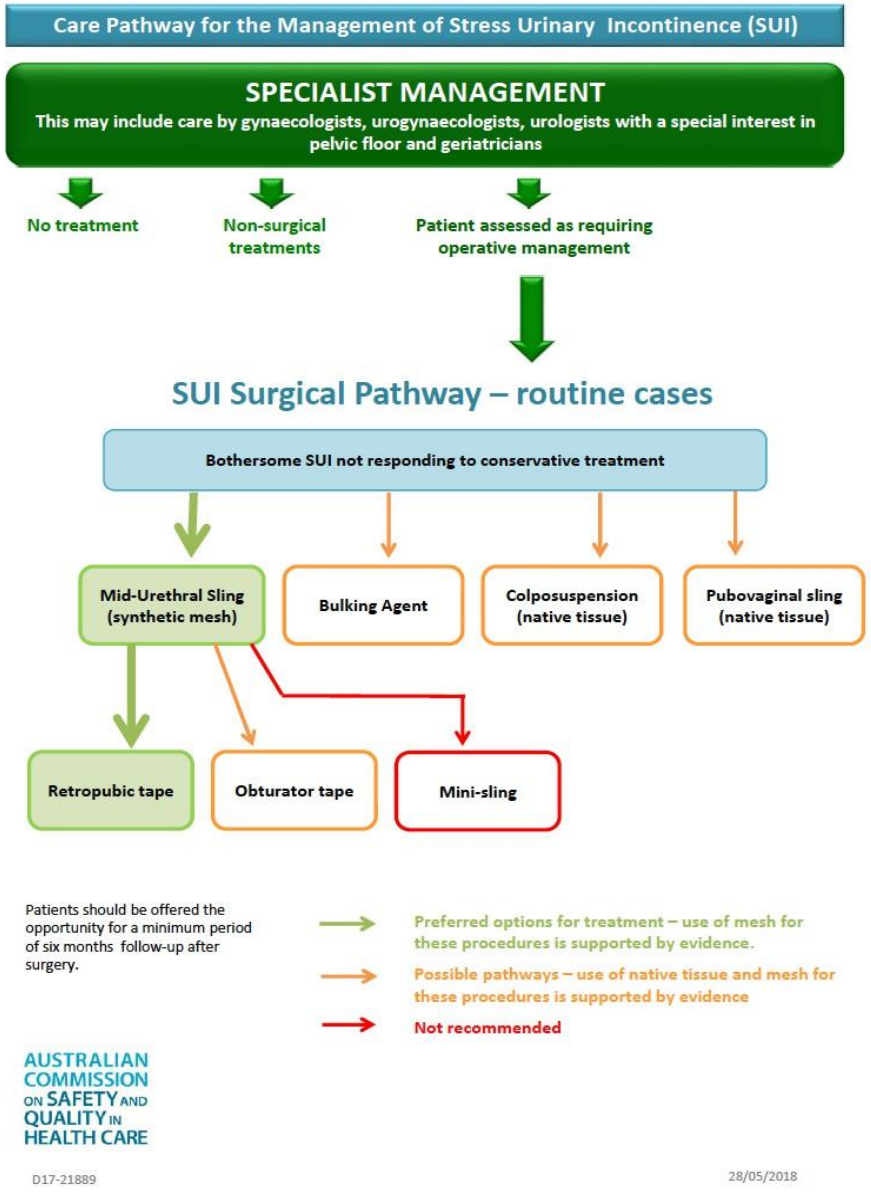
Queensland Pelvicfloorservices

ACSQHC – UI care pathway



https://www.safetyandquality.gov.au/publications-and-resources/resource-library/care-pathway-management-and-referral-urinary-incontinence-women

ACSQHC Specialist pathway - SUI



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Financial Assistance Continence Aids

•My Aged Care – Commonwealth Home Support Program. Patients or their nominated representative can apply:

- Online Aged Care Assessment Application
- Phone 1800-200-422

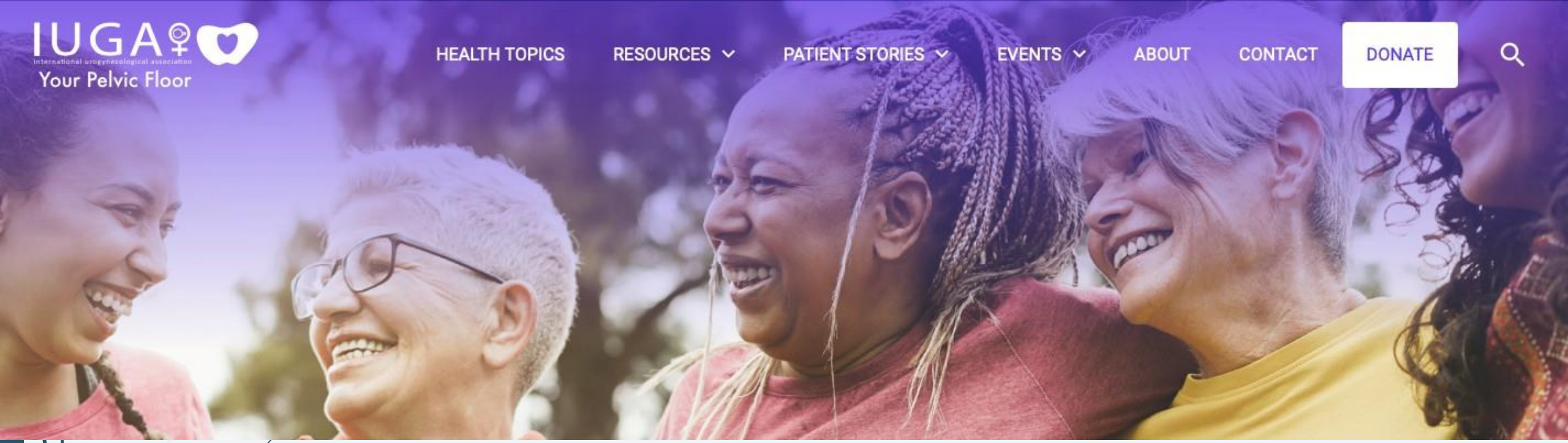
•Department of Veterans' Affairs – Rehabilitation Appliances Program (RAP)

- Assessment Guidance for Requesting Continence Products
- Direct Order Form: Continence Products – this form is for Health Care Providers only.
- Phone 1800-550-457 for assistance.

•Services Australia – Continence Aids Payment Scheme (CAPS)

- CAPS Application Form and Guidelines – a health professional must complete the Health Report component of the CAPS Application Form.
- Phone Medicare on 132-011 or the CAPS Team on 1800-239-309 for assistance in completing the CAPS application form.

Urinary Incontinence in Women - Community HealthPathways Brisbane South (SpotOnHealth)



https://www.yourpelvicfloor.org/leaflets/

Queensland Pelvicfloor services

Conclusions: Mixed urinary incontinence

- Variable presentation/history
- ?more severe form of urinary incontinence
- Less likely to regress/transition
- Risk factors – age, obesity

- Surgery
  - Reduced success SUI
  - OAB may persist or worsen – some urodynamics may provide guidance
  - If OAB improve, improvement reduces with time

- Current recommendation: ICI, ACSQHC
  - Initial conservative management

Queensland Pelvicfloorservices

THANK YOU / LET'S CONNECT

yuhwee@qpfs.com.au

https://qpfs.com.au

Queensland Pelvic Floor Services

Greenslopes Private Hospital
Suite 209, Level 2
Ramsay Specialist Centre
Newdegate Street
Greenslopes QLD 4120

Phone (07) 3847 9939

Queensland Pelvicfloorservices

Orange Group - Task 1

Katrina is 27 years old, G0P0, BMI 22 kg/m2

- Chronic abdominal pain & bloating
- Upper GI endoscopy & colonoscopy NAD
- Periods always been heavy and painful for 7-9 days, 25-day cycle prior to LNG-IUS insertion 8 months ago

Taking Naproxen, Esomeprazole, Oxycodone for ongoing pain

Pelvic USS – LNG-IUS in situ, “pelvic congestion syndrome”

Outline your approach

Metro South Health

Quality healthcare every day

Pelvic Pain

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

ICARE² values

INTEGRITY COMPASSION ACCOUNTABILITY RESPECT ENGAGEMENT EXCELLENCE

Queensland Government

When assessing pelvic pain

- Think of:
  - Original driver of pain?
  - Organ dysfunction – reproductive, bladder, bowel
  - MSK response to pain
  - Central sensitisation
  - Psychological sequelae of pain

Pelvic Pain

- **History of pain**
  - severity, timing of onset & duration, nature and location
  - ? cyclical nature, triggers, and relievers
  - age of menarche onset, dysmenorrhea, dyspareunia, bladder & bowel symptoms, associated bleeding or vaginal discharge
  - previous treatments and medications tried
  - previous pregnancies/contraceptive history, planned fertility
  - past medical and surgical history
  - social and emotional impact – including on work/sleep/relationships/sex-life, mental health impacts and/or diagnoses
  - Hx of STIs /physical and sexual abuse
- **FHx** - endometriosis, dysmenorrhoea, uterine structural abnormalities, and gynaecological cancers.

Assessment of patient with PPP

- Menses nature/relationship to pain
  - ? Heavy periods
  - ? Hormonal mx now/previous and did it help? Side effects?
  - Nature of pain/timing/location/duration
  - Progression over time
- Bladder
  - Pain?
  - Sensitisation/irritability – frequency/urgency/nocturia/UTI symptoms
  - Voiding dysfunction (?pelvic muscle dysfunction) – incomplete emptying, difficulty initiating voiding, episodes of urinary retention

Assessment of patient with PPP

- Bowels
  - Bowel habit
  - IBS symptoms
  - PR bleeding
  - ? Pain
    - Rectal pain? Relationship to menses? Relationship to opening bowels
    - Other bowel pain
- Sex
  - Pain
    - Deep vs superficial
    - Penetration/during/lingers afterwards – duration?
    - Apareunia

Assessment of patient with PPP

- Other pain
  - Dull background ache – locations? (tight/heavy/pulling/pressure/ache)
  - Sharp stabbing exacerbations – locations?
  - Other pains/pain conditions
    - Headaches/migraines
    - TMJ dysfunction
    - Fibromyalgia
    - IBS
    - Painful bladder syndrome
    - Other
- Sleep
- Impact of pain – what does it stop you doing? What would you like to do if not in pain?
- ED presentations for flares?
- **What do you think is causing your pain?**

Assessment of patient with PPP

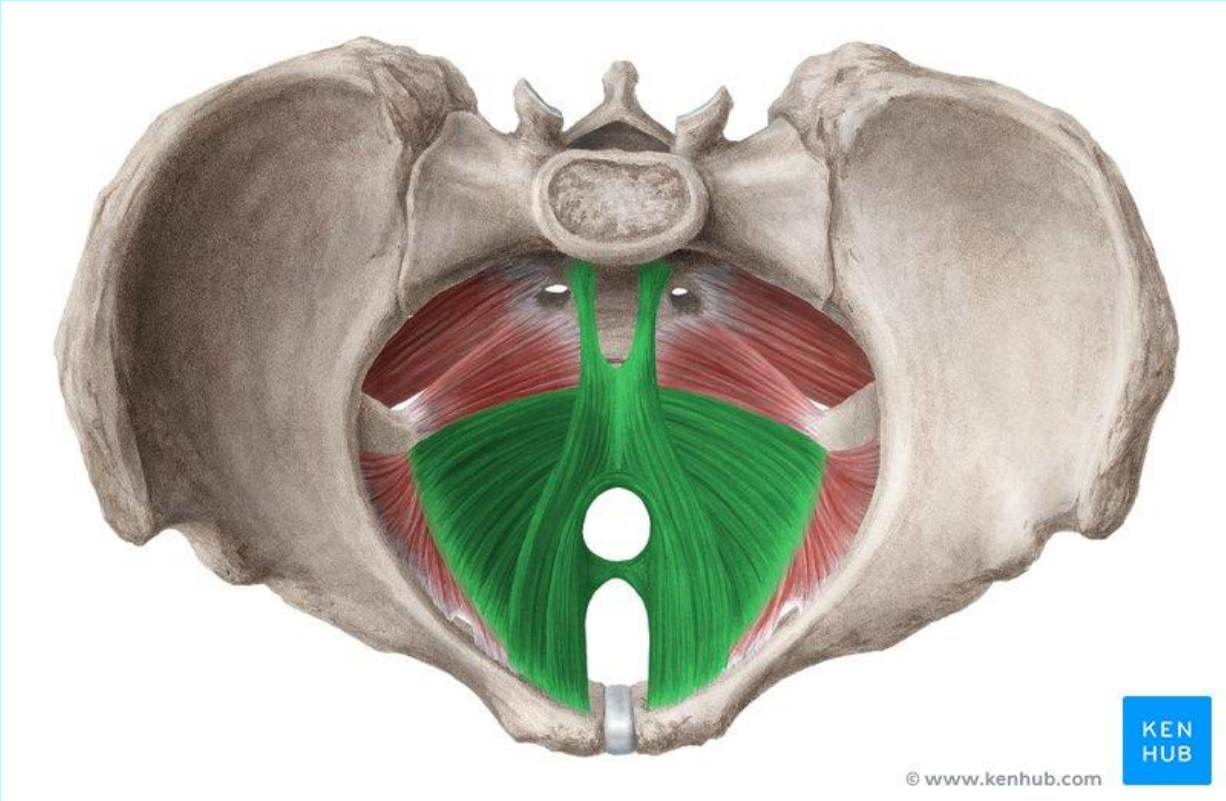
- What have you tried so far/currently using
  - Hormonal
  - Pain relief
    - NSAIDs – what and how do you use
    - Opioids/other
    - Neuromodulators – what/how used/duration/adverse effects?
  - Physio? Psych?
  - TENS
  - Flare management currently?
- Usual history (FHx/PMH/PSH/O&G/meds/Social)
  - Prev. gynae surgeries – findings, impact on pain/symptoms and duration, pictures, if possible, histology?

Pelvic Pain

- **Examination:**
  - Abdo/pelvis/vulval and vaginal Examination with and without speculum/PR
  - Weight/BMI (? weight loss)
  - Consider bloods – FBC/CRP +/- Urinalysis and pregnancy test – send urine for MCS
  - Cervical Screening Test, HVS M/C/S, cervical swab or urine PCR for Chlamydia/Gonorrhoea
  - Clinical Assessment Tools – menstrual or pain diary, bladder diary, pelvic pain assessment tool
  - Pelvic (if not sexually active) or /Transvaginal USS
  - Consider other imaging/investigations if other organ systems involved e.g. USS Abdomen. MRI, Colonoscopy
  - ? Refer for Laparoscopy – histology

Assessment of patient with PPP

- Physical exam
    - BMI
    - Abdo
    - Sometimes spec- depends on pain/goals – pretty hard to see vaginal endo in OPD unless very large lesion
        - Often very traumatic so mostly skip unless need CST or evaluation re AUB
    - Often just single digit VE
        - Levator Ani tone and tenderness?
        - Obturator internus tone and tenderness?
        - Does this reproduce same pain at all
        - Posterior fornix/USLs – nodularity, mobility, tenderness
    - Can sometimes palpate OI in posterior buttock if tenderness (eg not sexually active/unable to do pelvic exam)
- Investigations
    - STI screen, urine m/c/s, bloods if indicated eg FBC/ferritin
    - Imaging start with pelvic USS - ? Features of endo? Adeno?
        - Assess quality of scan +/- repeat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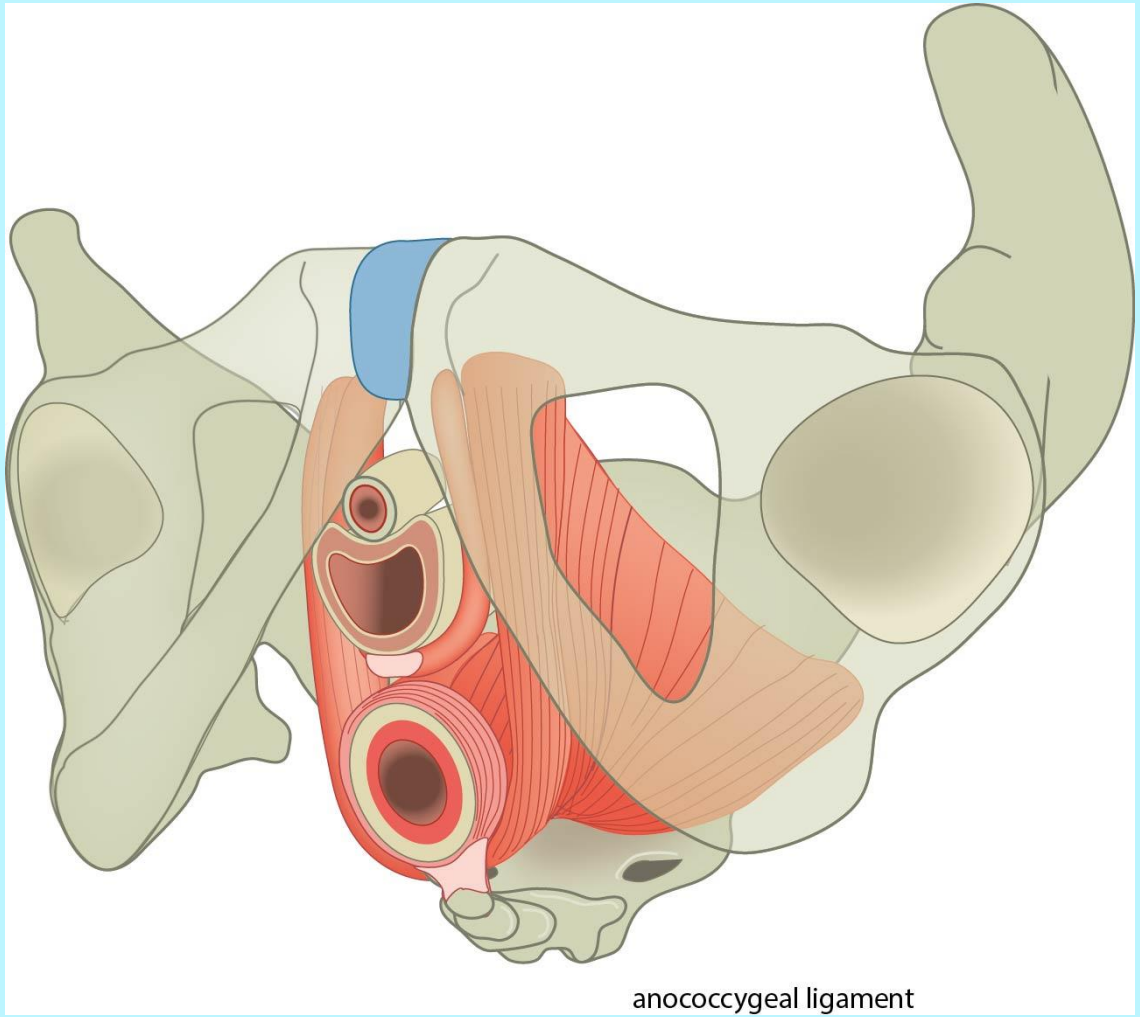
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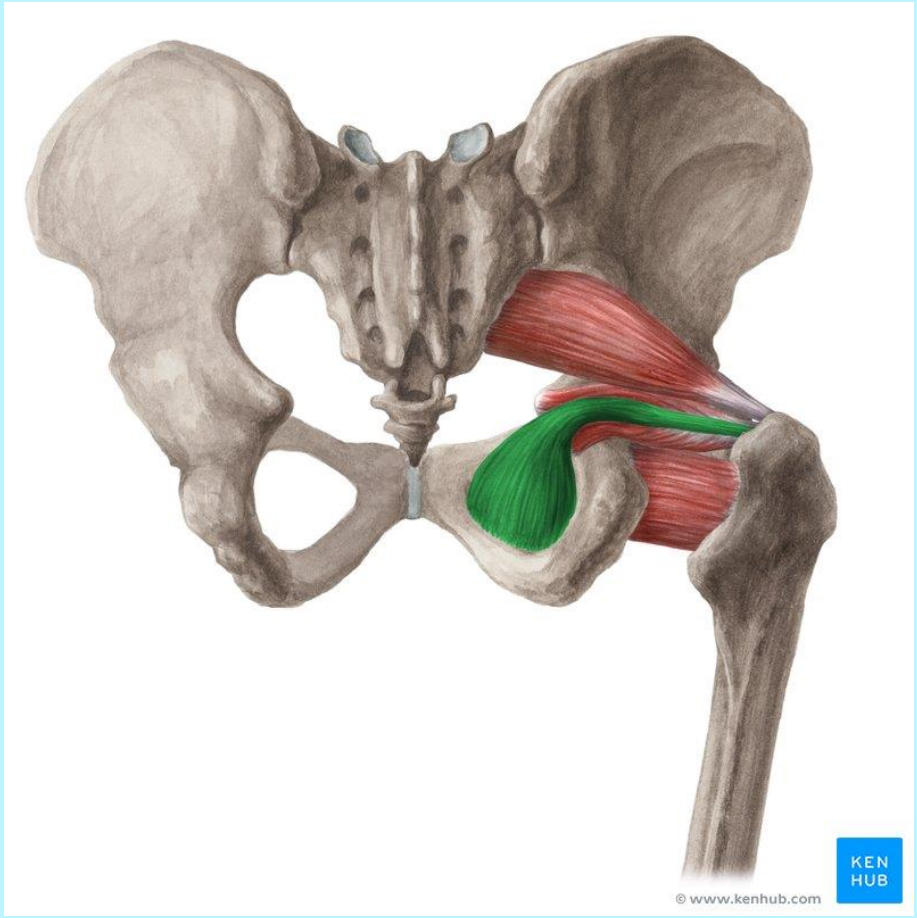
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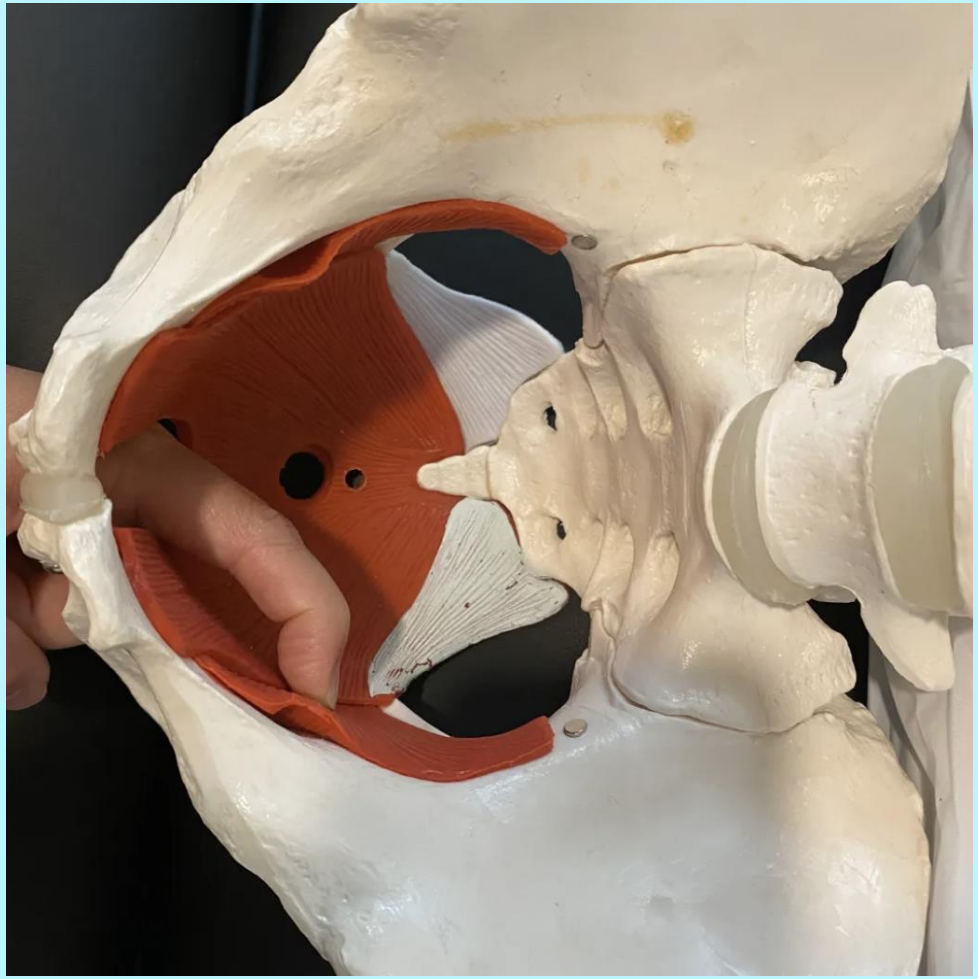
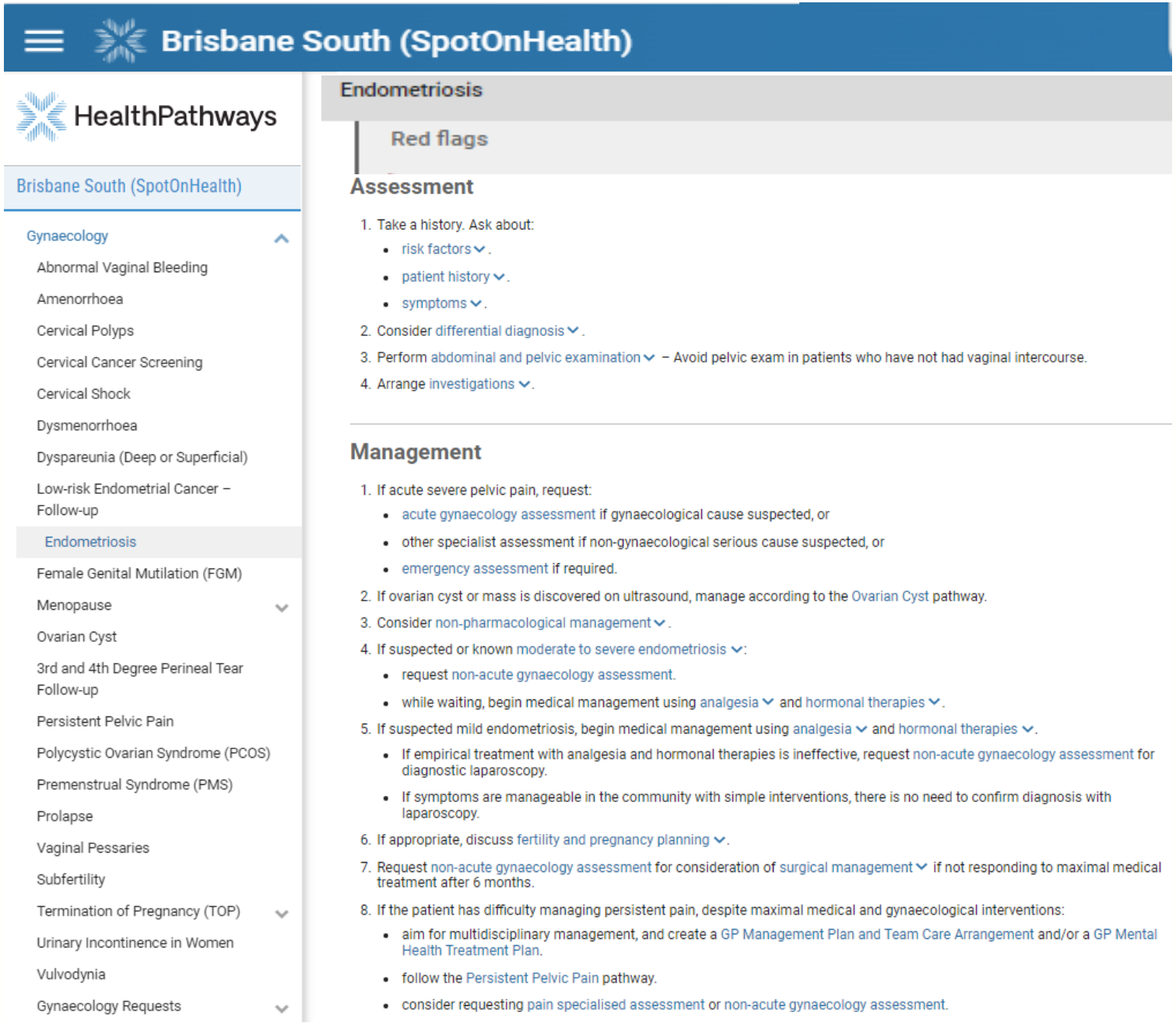




https://brisbanesouth.communityhealthpathways.org/30280.htm

- Perform targeted bimanual examination ^.

> **Bimanual examination**
>
> - Perform bimanual examination with particular attention to:
>   - the lateral pelvic walls for levator ani spasm and tenderness.
>   - cervical pain and adnexal tenderness. This could indicate pelvic inflammatory disease (PID).
>   - Run the fingers posteriorly from the cervix to the utero-sacral ligaments to check for tenderness and nodularity, which is typical of endometriosis.
>   - Examine anteriorly to identify urethral and bladder discomfort.

- Perform rectal exam to exclude a mass or chronic constipation.

https://brisbanesouth.communityhealthpathways.org/13407.htm

The aims of examination are to assess the relative importance of each component of the patient's pain and exclude
infection. A sequence of examination may include:

- **Gait:** slow, awkward rising from a chair, slow walk from the waiting room or sudden sharp pains are suggestive of pelvic muscle pain
- **Palpation of the lower back and gluteal muscles:** tenderness of gluteus medius, coccyx and sacroiliac joints posteriorly; tenderness is common in conjunction with intra-pelvic muscle dysfunction
- **Palpation of Abdomen:** signs of extensive heat pack use, for masses or tender points in rectus abdominus
- **Assessment of cold sensation (optional):** reduced cold sensation in the area of maximal pain may be present (Figure 2) and is suggestive of nerve pathway involvement

Vulva and Vaginal Examination with or without speculum

- Vulva skin irritation, atrophic vaginal skin, vaginal discharge , exclusion of sexually transmitted infections
- **Cotton tip swab assessment**; vaginal introital sensitivity between 4 and 8 o'clock near Bartholins Glands suggests provoked vulvar vestibulodynia
- **One-finger vaginal examination of the pelvic floor and obturator internus:** the pelvic floor muscles are palpated
  (stroked) laterally just inside the vagina; the obturator internus is palpated slightly deeper at the level of the mid vagina by pressing laterally toward the hip. The right obturator internus will become tight and easier to palpate with your right forefinger when the patient's flexed right knee is abducted laterally against your externally placed left hand;
  the left obturator internus is easier to palpate with your left forefinger vaginally and her left leg abducted laterally against your externally placed right hand. Where pelvic floor muscles are already tight, further contraction and then relaxation of the pelvic muscles around the examiners fingers on request may not be possible.
- vaginal examination: uterus and adnexae, then bladder and urethra through anterior vaginal wall

Examination of a Patient with Chronic Pelvic Pain - Pelvic Pain Foundation

Differential Diagnosis: Common causes of persistent pelvic pain

Gynaecological:

- Endometriosis
- Adenomyosis
- Chronic pelvic inflammatory disease (PID)
- Vulvodynia
- Pelvic congestion syndrome

Urological:

- Interstitial cystitis (painful bladder syndrome)
- Recurrent UTI

Gastrointestinal:

- Irritable bowel syndrome (IBS)
- Diverticular disease
- Coeliac disease
- Constipation
- Inflammatory bowel disease (IBD)
- Adhesions due to endometriosis, previous surgery or previous pelvic infection

Musculoskeletal:

- Pelvic floor spasm or myalgia
- Levator ani syndrome
- Coccydynia
- Fibromyalgia
- Chronic abdomen wall pain
- Vaginismus

Neurological:

- Neuralgia which may be associated with previous surgery including previous diagnostic laparoscopy
- Central sensitisation

Psychological:

- Depression, anxiety
- Sexual abuse
- Somatisation
- Opiate dependency

https://brisbanesouth.communityhealthpathways.org/13407.htm

Is persistent pelvic pain a diagnosis in itself?

Symptoms of Endometriosis - highly variable, correlate very poorly with location and extent of lesions/staging, none are specific to endometriosis

- Pain
  - Dysmenorrhoea (60-80%)
  - Deep Dyspareunia (40-50%)
  - Chronic Pelvic Pain (40-50%)
  - Ovulation Pain
  - Low Back Pain
- Subfertility (30-50%)
- Menstrual symptoms
  - HMB (10-20%)
  - Premenstrual spotting (common)
  - Other menstrual disturbance
- Gastrointestinal symptoms (cyclical):
  - Dyschezia
  - Tenesmus
  - Rectal bleeding
  - Faecal urgency
  - Abdominal bloating (10 to 40%)
  - Irritable bowel syndrome (IBS) symptoms – constipation, diarrhoea
- Urinary symptoms (cyclical):
  - Dysuria (5%)
  - Urine frequency
  - Haematuria
- Significant lethargy before/ during menses

Recommend a menstrual diary to document symptoms e.g., Jean Hailes – Pain and Symptom Diary or Endometriosis Australia – Pain Tracker

Endometriosis - Community HealthPathways Brisbane South (SpotOnHealth)

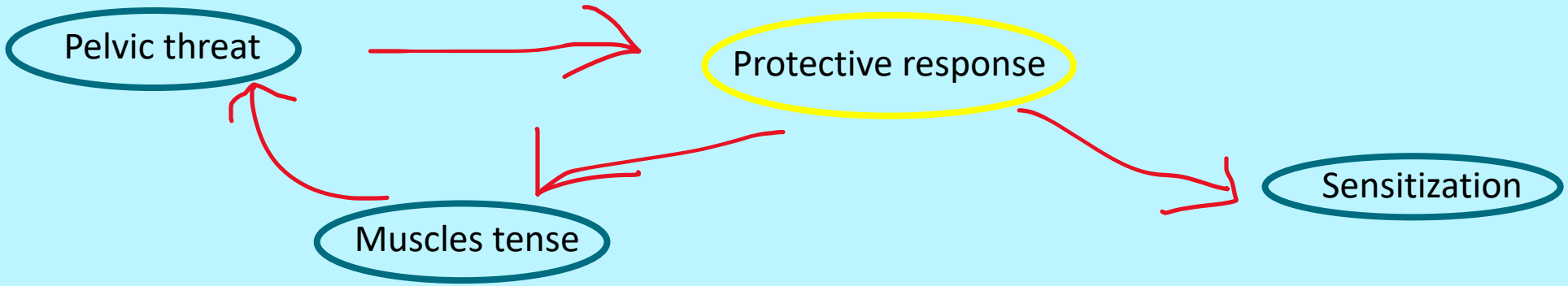
RED FLAGS

- Abnormal vaginal bleeding
- PR Bleeding
- Change in bowel habit in > 40yo
- New onset of pain after menopause
- Pelvic mass
- Weight loss
- Suicidal ideation

When managing pelvic pain

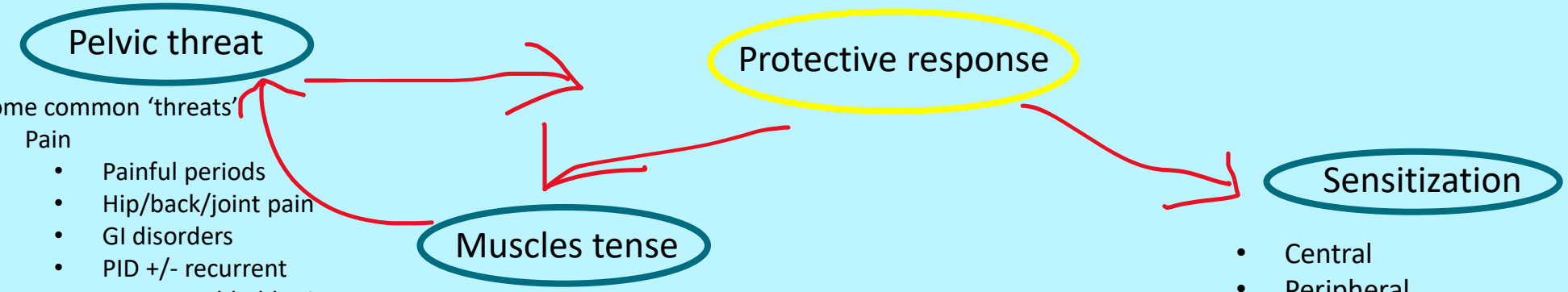
- Think of:
  - Original driver/s of pain?
  - Organ dysfunction – reproductive, bladder, bowel
  - MSK response to pain
  - Central sensitisation
  - Psychological sequelae of pain

How I talk about (and manage) persistent pelvic pain…



→ Not everyone will have all aspects equally but I find this a helpful framework for approaching their pain and planning/structuring management

How I talk about (and manage) persistent pelvic pain…



Some common 'threats'

- Pain
  - Painful periods
  - Hip/back/joint pain
  - GI disorders
  - PID +/- recurrent
  - Recurrent bladder issues
  - Surgery/surgical complications
  - Recurrent vulval irritation
- Anxiety
- Stress
- Trauma (medical/sexual/other)

WORK OUT WHAT THE INITIAL THREAT/S ARE AND ADDRESS THEM

- Eg if started with painful periods – then address that
  - NSAIDs with periods
  - Hormonal suppression of menses
  - Consider referral for surgical treatments (excision of endometriosis, hysterectomy)

Be mindful that surgery is both investigation and treatment, but also another 'threat' that can worsen pain – so lots of merit in working on other factors first and shouldn't delay initiating other treatments

Discuss how muscle tension/spasms cause symptoms

Discuss usual mx eg

- Stretches (from PPFA)
- Physio - refer
- Movement – pacing, type matters

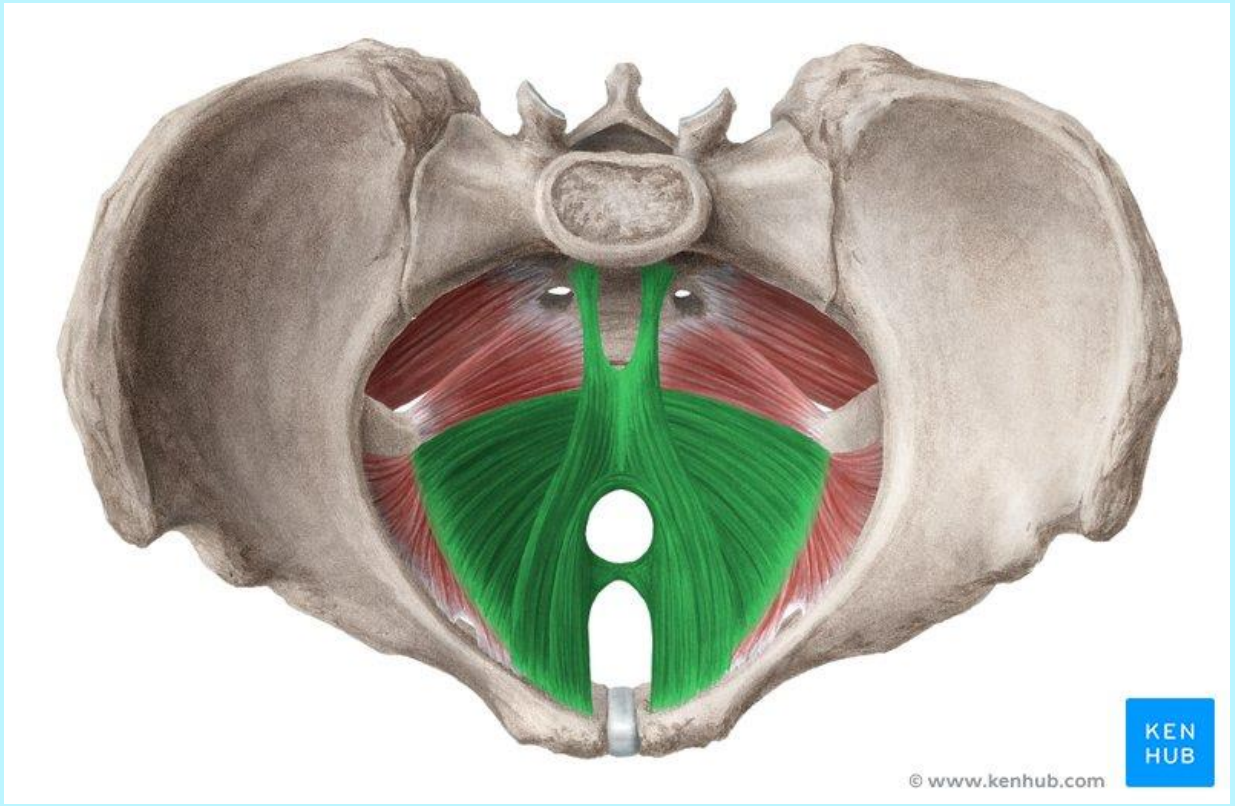
- Occ – Botox to pelvic muscles
- Flare mx:
  - Breathing, stretches
  - Mindfulness
  - Heat
  - NSAIDs – optimize dosing
  - Diazepam supps

- Central
- Peripheral
- Cross-sensitisation/viscerovisceral

- Discuss how this presents/associated symptoms esp if they have them!
  - Bowel/bladder/increased pain/sleep/headaches etc

- Discuss factors that influence/contribute (and address as appropriate):
  - Sleep
  - Mood – anxiety/stress/depression
  - Movement/exercise
  - Trauma
  - Social functioning – work/school/friends/fun
  - Other inflammatory conditions
  - Other pain conditions

- Role of neuromodulators (+/- initiate)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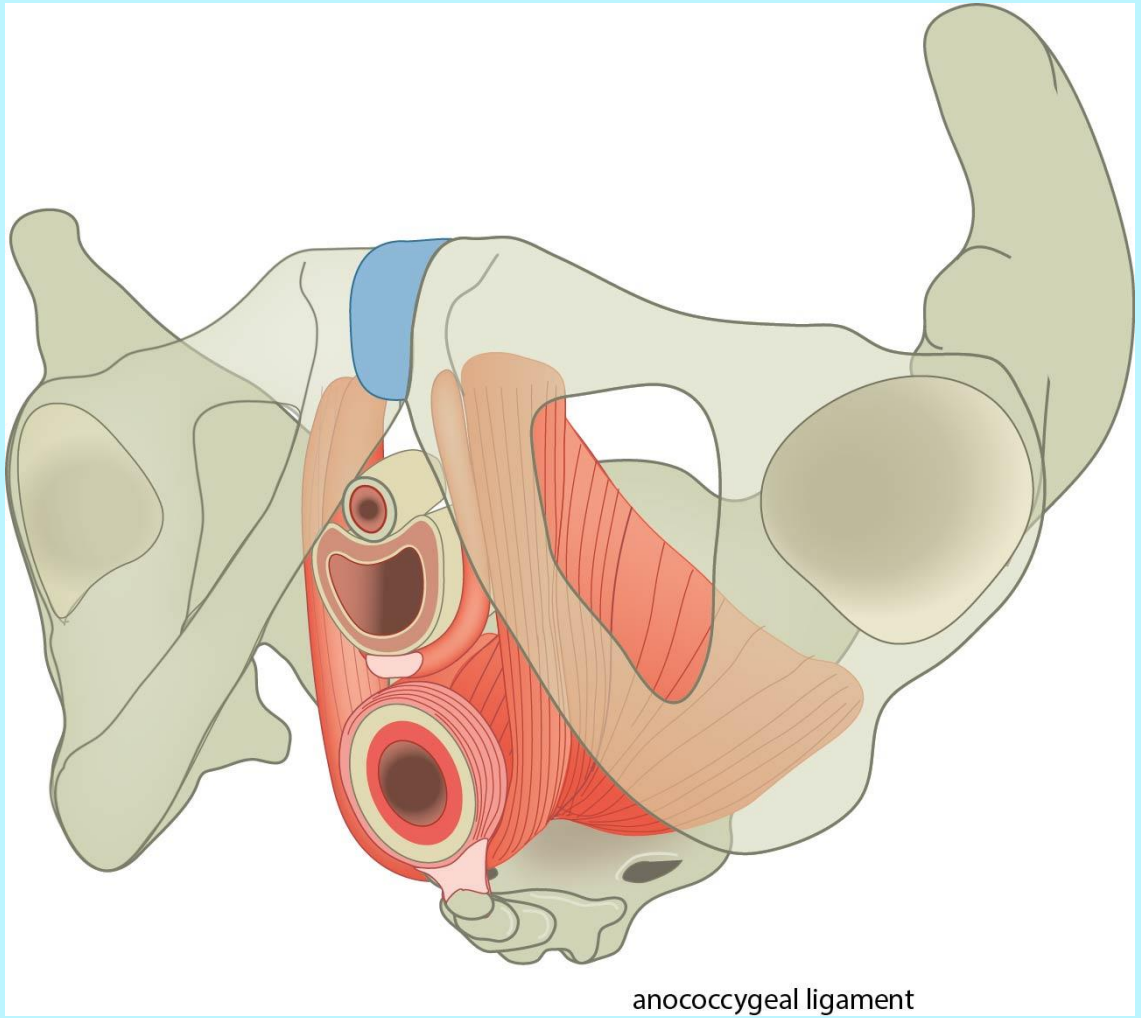
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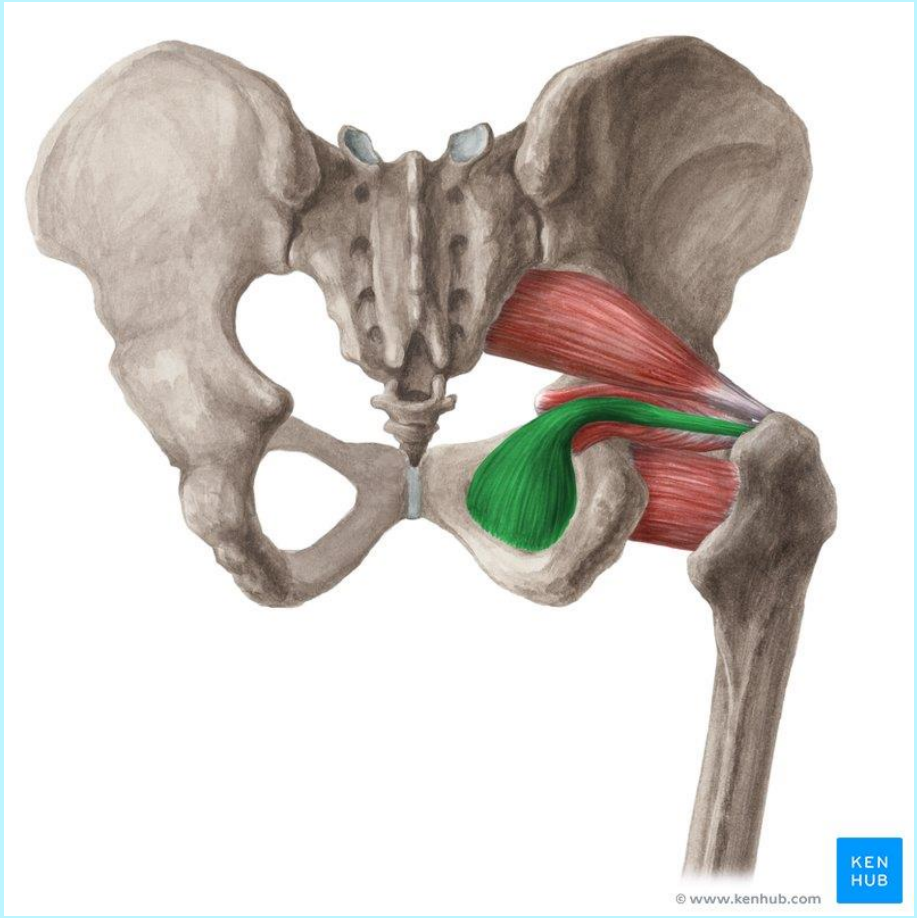
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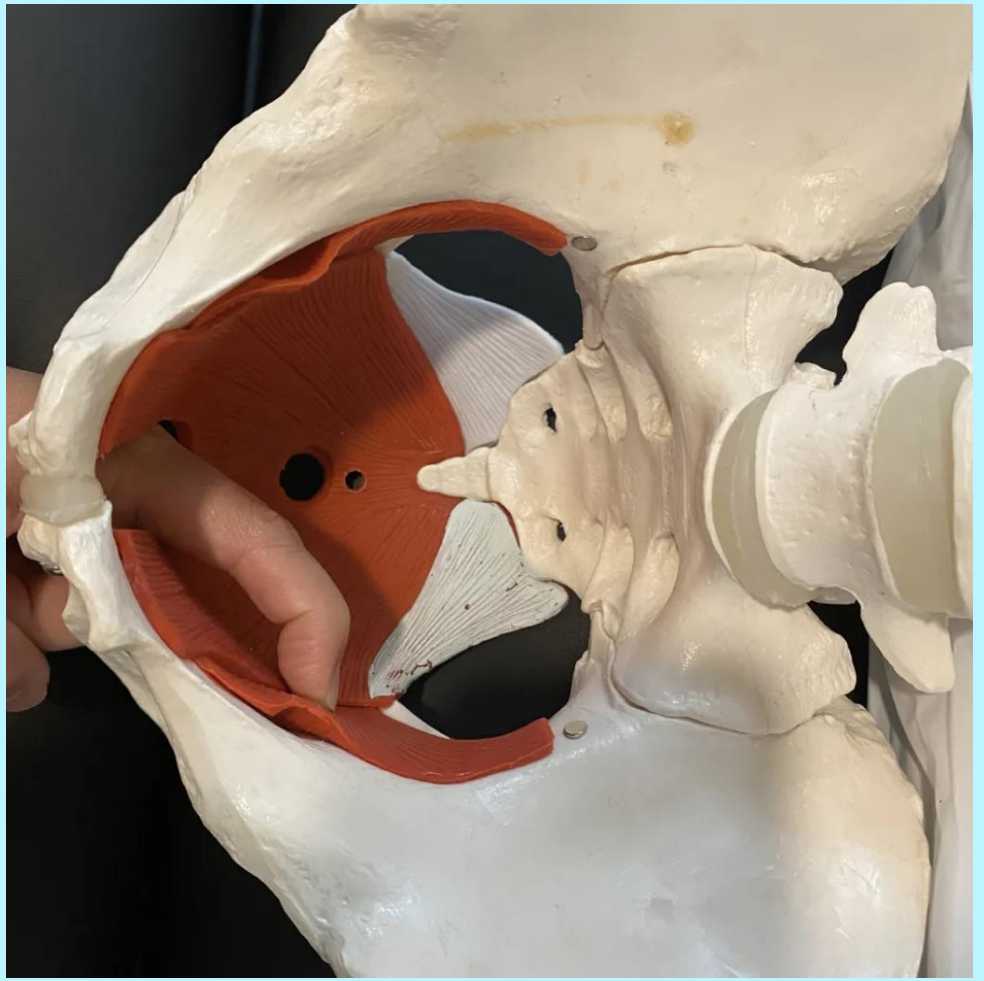
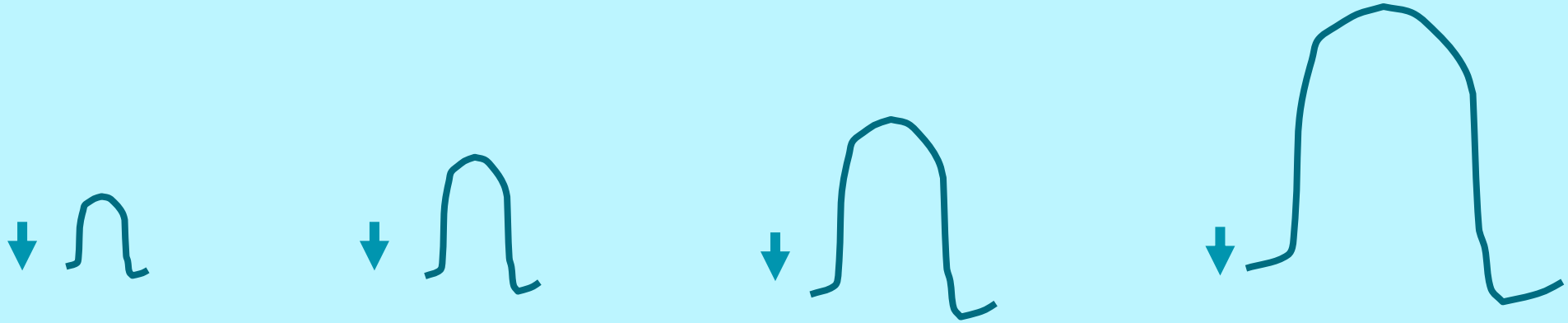
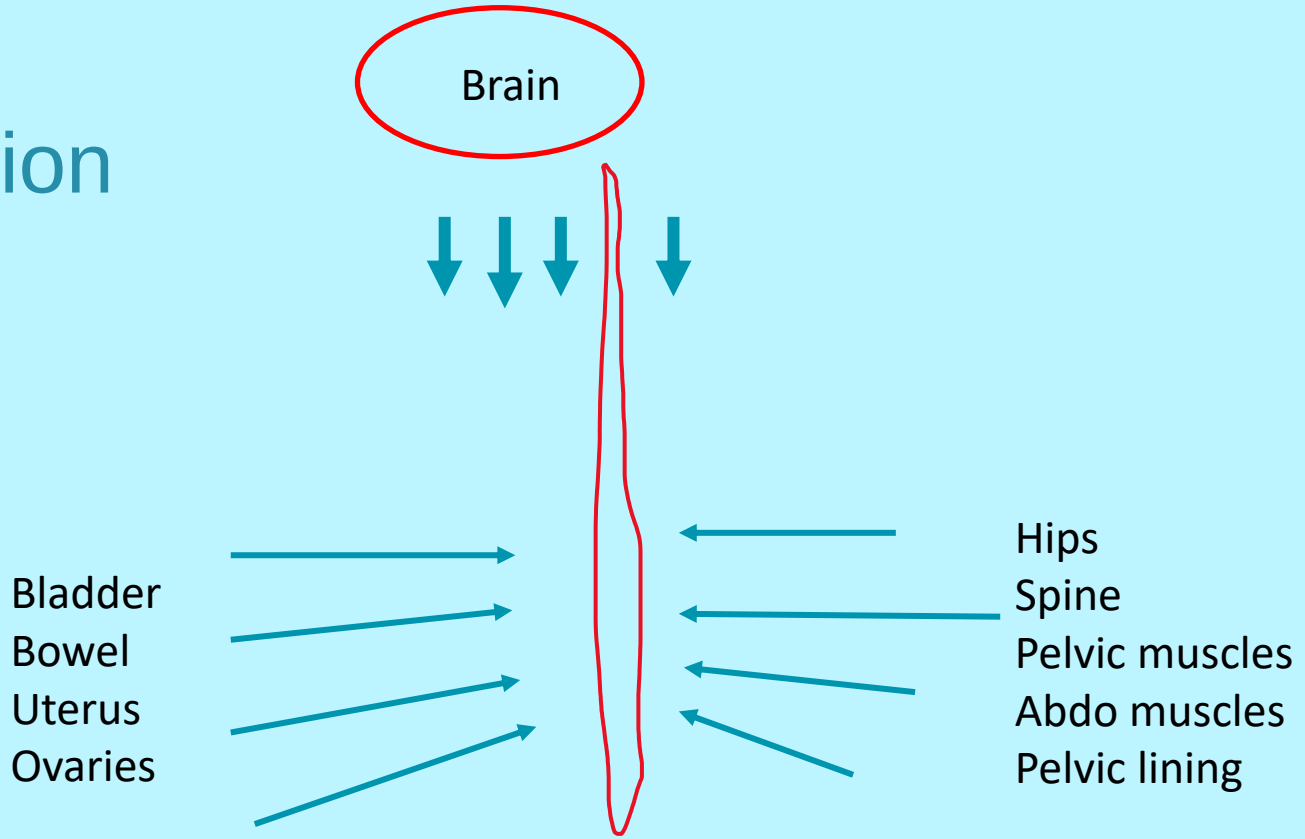




Discussing sensitisation



Important pain science education concepts for female individuals with persistent pelvic pain.

Source

"I wish I knew then what I know now" — pain science education concepts important for female persistent pelvic pain: a reflexive thematic analysis

PAIN165(9):1990-2001, September 2024.

PAIN 165(9):p 1990-2001, September 2024. PAIN (lww.com)

Chronic Pelvic Pain – what are realistic goals of treatment?
- careful counselling & maximised patient understanding needs to guide these goals.

Management of Chronic Pelvic Pain

Once pain is persistent, a reduction in pain together with improved function and wellbeing may be more achievable goals than cure. Even so, substantial improvement is achievable with the right team of health professionals. Start with simple analgesia such as paracetamol ad nonsteroidal anti-inflammatory drugs.

Dysmenorrhoea

Dysmenorrhoea is often only one component of CPP. If endometriosis, dysmenorrhoea, or cyclical aggravations of pain are present, the aim to management is to minimise the number of periods or the amount of bleeding by creating a progestogenic (decidualised) environment. Amenorrhoea is optimal, but may require a combination of treatments (eg levonorgestrel IUCD and continuous OCP, or levonorgestrel IUCD and oral dienogest).

Management includes:

- A monophasic oral contraceptive pill (OCP)
- Oral progestogen (dienogest 2 mg or norethisterone 5 mg) or levonorgestrel intrauterine contraceptive device (IUCD)
- The etonorgestrel implant may be effective if amenorrhoea can be achieved
- For severe cases, dienogest 2 mg daily continuously has been shown to be non-inferior to GnRH agonists, has fewer hypoestrogenic side effects and improved quality of life.[11]

Hysterectomy treats dysmenorrhoea well when fertility is no longer an issue. However, a hysterectomy should not be considered as a cure for CPP, as it is possible pain can persist despite the hysterectomy due to the pre-existing muscle tightness, central sensitization and psychological distress.

Bladder symptoms

These symptoms may be due to a range of conditions; however, painful bladder syndrome is common.12 'Flares' resemble urinary tract infections, but urine cultures are negative despite haematuria.

Management includes:

Assessing and excluding potential diet triggers, particularly acidic foods/drinks (citrus fruits, fizzy drinks, caffeine, cranberries, artificial sweeteners, tomatoes) drinking 1.5–2 L fluid daily (mostly water) in normal weather

Acute management of flares (ie drinking 500 mL water mixed with 1 teaspoon bicarbonate of soda or two urine alkalinising sachets, then 250 mL water every 20 minutes for a few hours); antibiotics should be avoided unless infection is proven; providing a request form for urine culture if symptoms flare provides security that urine infection will not be missed

use of medications including amitriptyline, oxybutinin, solifenacin and others, as outlined by Lau et al,[13] (amitriptyline has the added advantage of helping with sleep, headaches, the persistent pain condition, pelvic muscle pains and some irritable bowel symptoms, and is a good first choice.)

Vulvovaginal irritation

Management depends on the conditions present and includes:

- Avoiding soap/perfumed body wash – replace with QV/Cetaphil or Dermaveen body wash, and water only on vulval area
- Exclusion of candidiasis – where repeated episodes of candidiasis have been proven, fluconazole 200 mg every 72 hours for three doses then weekly for 6 months as a private prescription is effective[14]
- Low-dose amitriptyline, this can be compounded as a topical agent
- Vulval dermatological review
- Topical oestrogen if patient is post-menopausal
- Pelvic physiotherapy.

Pudendal neuralgia

Pudendal neuralgia causes a burning or sharp pain in the 'saddle' area, anywhere from the clitoris back to the anal area, when sitting. It may be uni- or bilateral and may be associated with increased clitoral arousal.[17]

Management includes:

- Avoiding activities that compress the nerve, such as cycling, crossing legs
- Using a 'U-shaped' foam cushion with the front and centre area cut out when sitting
- pelvic physiotherapy to down train pelvic muscles and reduce pressure on pudendal nerve
- ceasing straining with bowels or bladder
- neuropathic medications.

Managing pelvic muscle pain

Diagnosing the pain correctly may avoid unnecessary treatments and procedures.

Management options include:

- Avoiding aggravating activities (eg core strengthening exercise, prolonged positions)
- Stretches
- Yoga and mindfulness
- Vaginal dilators
- pelvic physiotherapy to 'down-train' muscles
- optimising bladder and bowel function
- botulinum toxin injection for severe cases.- Referral to Gynaecologist[18]

Managing central sensitisation

Management includes:

- an explanation that the nerve pathways have physically changed and become sensitised
- exercise – 'the best non-drug treatment for pain' (eg walking; where inactive, start with time outside each day, then a short daily walk with pacing to avoid over-tiredness)
- optimisation of sleep patterns[19]
- pain psychology
- neuropathic medications such as low dose amitriptyline, a serotonin-noradrenaline re-uptake inhibitor (SNRI) such as duloxetine, or an anticonvulsant such as pregabalin; in women, use small doses and increase slowly to a low peak dose (eg amitriptyline 5 mg 1–3 hours before bed, slowly increasing to 5–

https://www.pelvicpain.org.au/about/for-health-professionals/for-health-professionals-management-of-chronic-pelvic-pain/

Pelvic Pain

Non-Pharmacological

- Heat packs, Magnesium supplements, TENS, Acupuncture,
- Alternative and complementary therapies (may interfere with other prescribed medications)
- Optimise BMI
- Increase exercise esp. walking and general fitness, but avoid aggravating activities e.g. core strengthening exercise/ prolonged positioning
- Meditation, Yoga, Stretching exercises, Breathing techniques incl pelvic floor muscle relaxation
- Optimise sleep
- Offer patient support and listen/follow up/educate re chronic pain and pain psychology
- Link to support groups e.g. Endometriosis Australia
- Mental Health input as required – Counselling. Psychological assessment and therapy, +/- Psychiatrist input, Sex Therapy, Relationship Counselling
- Women's Health Physiotherapy input – pelvic floor relaxation and address pelvic floor dysfunction (? Team Care Plan for multidisciplinary management)
- **Multidisciplinary Team input is the GOLD Standard**

Easy Stretches to Relax the Pelvis (pelvicpain.org.au)
Pelvic Pain Foundation

Pharmacological

- Paracetamol/NSAIDS
- Hormonal: Trial each treatment option for ≥ 3 months
  - COCP Monophasic (continuous or tricycling after first cycle – if has BTB after taking continuously for 3/52, break for 4-7 so has withdrawal bleed, then recommence)
  - Progestogen: LARCs – MIRENA (+/- add COCP if ovulation suppression not achieved), Implanon (if establish amenorrhoea), DMPA (if establish amenorrhoea, but risk of reduced BMD long-term); Slinda
  - or continuous higher dose oral progestogen but not contraceptive, more SE and may affect lipids & BMD (MPA 10mg bd; Norethisterone 5mg bd or Dienogest (Visanne) 2mg once daily
- Neuromodulators e.g., tricyclic antidepressants(low dose Amitriptyline. Nortriptyline; SNRIs (Duloxetine); anticonvulsants, pregabalin (pregnancy category D) and gabapentin – consider if the patient has central sensitisation*
- Avoid opioids

Gynaecological Review:

GnRH analogues – may be very effective in reducing pain + containing endometriotic deposits, but SE of menopause-like symptoms + bone thinning, not contraceptive, can only be 6/12 on PBS + symptoms may recur after ceased (GnRH agonist + add-back – Ryeqo – now available in Aus)

Botulinum toxin injection for severe cases

Surgery – laparoscopy for diagnosis & treatment, ablation, excision, cystectomy for endometrioma, hysterectomy

Final advice

- These patients take time and are challenging
  - Luxury in specialty practice of being able to plan longer appointments and triage referrals that way from outset (at least in private!)
  - Need to allow extra time/multiple appointments
  - May need to address different aspects over staged appointments – but important to understand that multimodal approach from outset is more effective for PPP than single intervention/stepwise approach

Resources

- RANZCOG Endometriosis eLearning Module
  - https://acquire.ranzcog.edu.au/mod/page/view.php?id=13314
  - (40 CPD points/6hrs CPD for RACGP, up to 6hrs PDP for ACRRM; up to 6hrs CPD for RANZCOG)

- RATE tool https://ranzcog.edu.au/resources/raising-awareness-tool-for-endometriosis-rate/

- Better Pain Management:
  - Written by pain specialists for other medical professionals (CPD points) - $315 cost
  - www.betterpainmanagement.com

- Pelvic Pain Foundation of Australia www.pelvicpain.org.au – everything
  - Stretches
  - Tips and tricks to recovering well from laparoscopy
  - Help with medications info pages
  - For Women and AFAB/for Teens home pages (and tips for parents of teens with pelvic pain)
  - E-book

Resources

- Pelvic Pain - Australian Journal Of General Practice, Jan-Feb 2024 Vol 53, Issue 1-2 RACGP - January–February https://www1.racgp.org.au/ajgp/2024/january-february

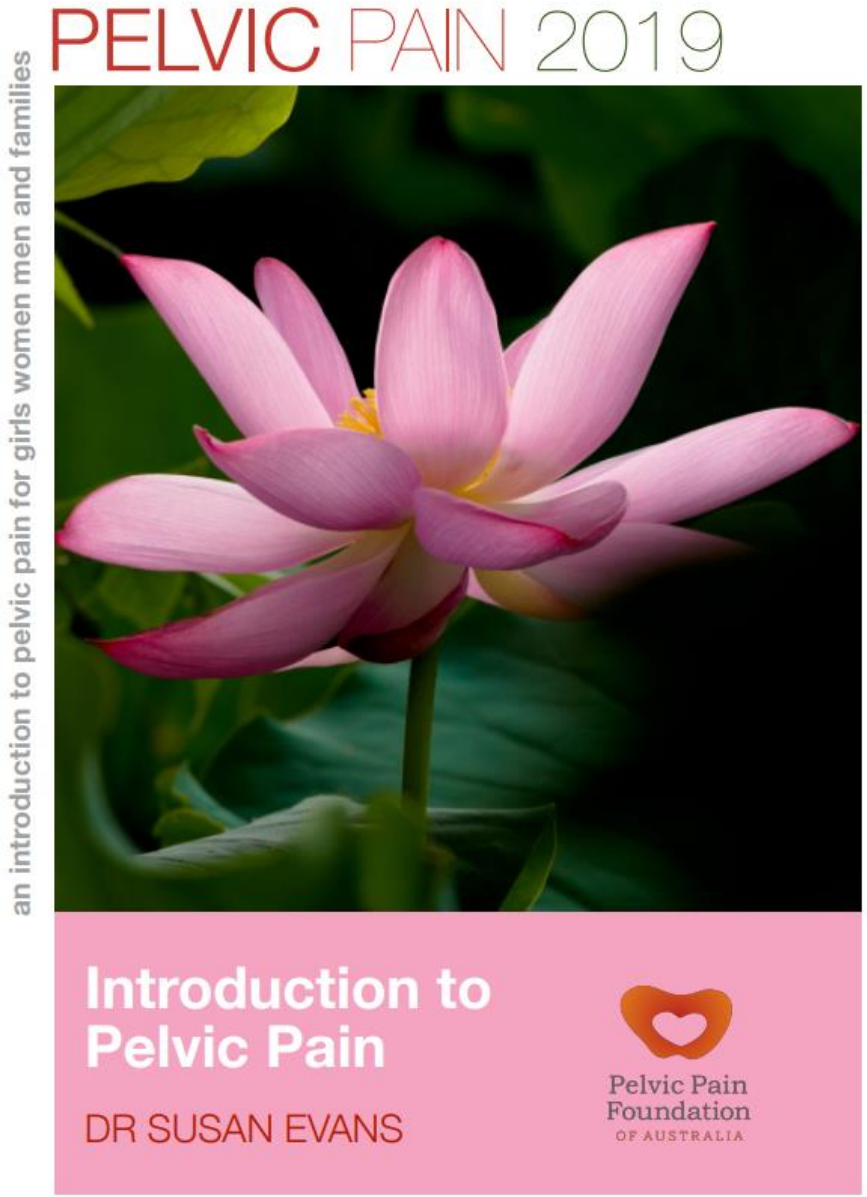
- Dysmenorrhea: An update on primary healthcare management - Australian Journal Of General Practice, Jan-Feb 2024 Vol 53, Issue 1-2 by Dr Katie Christensen RACGP - Dysmenorrhea

- Endometriosis – current management options –Jason Abbott, Medicine Today April 2021; 22(4): 33-36 https://medicinetoday.com.au/system/files/pdf/MT2021-04-033-ABBOTT.pdf

- Treating endometriosis | The Royal Women's Hospital (thewomens.org.au) – Patient Fact Sheet

AJGP: Pelvic pain

Chronic pelvic pain can be challenging for practitioners but more especially patients. Understanding its nature and the range of available therapies can assist significantly.



"Introduction to Pelvic Pain 2019" - Downloads - Pelvic Pain Foundation

For Health Professionals

Chronic Pelvic Pain (CPP) can be defined as pain in the area of the pelvis that has been present on most days for more than six months.1 CPP is estimated to affect 15–25% of Australian Women and 8% of Australian Men.3

With so many people affected, general practitioners (GPs) will provide the majority of care for this condition and are essential in coordinating patient care with other specialists and health professionals.

Despite this, few guidelines for management are available, and few medical practitioners feel adequately skilled to manage the complex range of symptoms that present. This website provides a practical framework for the clinical assessment and management of CPP in general practice.

For Health Professionals - Pelvic Pain Foundation

Chronic Pelvic Pain, like other chronic pains, can be broken down to four parts:

- Pain from pelvic organs
- The musculoskeletal response to pain
- Central sensitisation of nerve pain pathways
- Psychological sequelae of chronic pain including the stigma and effects of self-identity surrounding gender, fertility and sexuality.

THE INTERNATIONAL PELVIC PAIN SOCIETY

Professionals engaged in pain management for women

Pelvic Pain Assessment Form

Physician: _____

Initial History and Physical Exam

Date: _____

Contact Information

Name: _____ Birth Date: _____ Chart Number: _____

Phone: Work: _____ Home: _____

Is there an alternate contact if we cannot reach you? _____

Alternate contact phone number: _____

Information About Your Pain

Please describe your pain problem: _____

What do you think is causing your pain? _____

What does your family think is causing your pain? _____

Do you think anyone is to blame for your pain? ❑ Yes ❑ No If so, who? _____

Do you think surgery will be necessary? ❑ Yes ❑ No

Is there an event that you associate with the onset of pain? ❑ Yes ❑ No If so, what? _____

How long have you had this pain? ❑ < 6 months ❑ 6 months – 1 year ❑ 1 – 2 years ❑ > 2 years

For each of the symptoms listed below, please "bubble in" your level of pain over the last month using a 10-point scale:

0 – no pain 10 – the worst pain imaginable

	0	1	2	3	4	5	6	7	8	9	10
How would you rate your present pain?											
Pain at ovulation (mid-cycle)	○	○	○	○	○	○	○	○	○	○	○
Pain level just before period	○	○	○	○	○	○	○	○	○	○	○
Pain (not cramps) with period	○	○	○	○	○	○	○	○	○	○	○
Deep pain with intercourse	○	○	○	○	○	○	○	○	○	○	○
Pain in groin when lifting	○	○	○	○	○	○	○	○	○	○	○
Pelvic pain lasting hours or days after intercourse	○	○	○	○	○	○	○	○	○	○	○
Pain when bladder is full	○	○	○	○	○	○	○	○	○	○	○
Muscle/joint pain	○	○	○	○	○	○	○	○	○	○	○
Ovarian pain	○	○	○	○	○	○	○	○	○	○	○
Level of cramps with period	○	○	○	○	○	○	○	○	○	○	○
Pain after period is over	○	○	○	○	○	○	○	○	○	○	○
Burning vaginal pain with sex	○	○	○	○	○	○	○	○	○	○	○
Pain with urination	○	○	○	○	○	○	○	○	○	○	○
Backache	○	○	○	○	○	○	○	○	○	○	○
Migraine headache	○	○	○	○	○	○	○	○	○	○	○
What would be an acceptable level of pain?	○	○	○	○	○	○	○	○	○	○	○

What is the worst type of pain that you have ever experienced?

❑ Kidney stone ❑ Bowel obstruction ❑ Migraine headache

❑ Labor & delivery ❑ Current pelvic pain ❑ Backache

❑ Broken bone ❑ Surgery

❑ Other _____

(205) 877-2950 www.pelvicpain.org (800) 624-9676 (if in the U.S.)

http://www.healthyinfo.com/staff/forms/Pelvic.Pain.Hx.pdf - Pelvic.Pain.Hx.pdf (healthyinfo.com) – Pelvic Pain Assessment Form

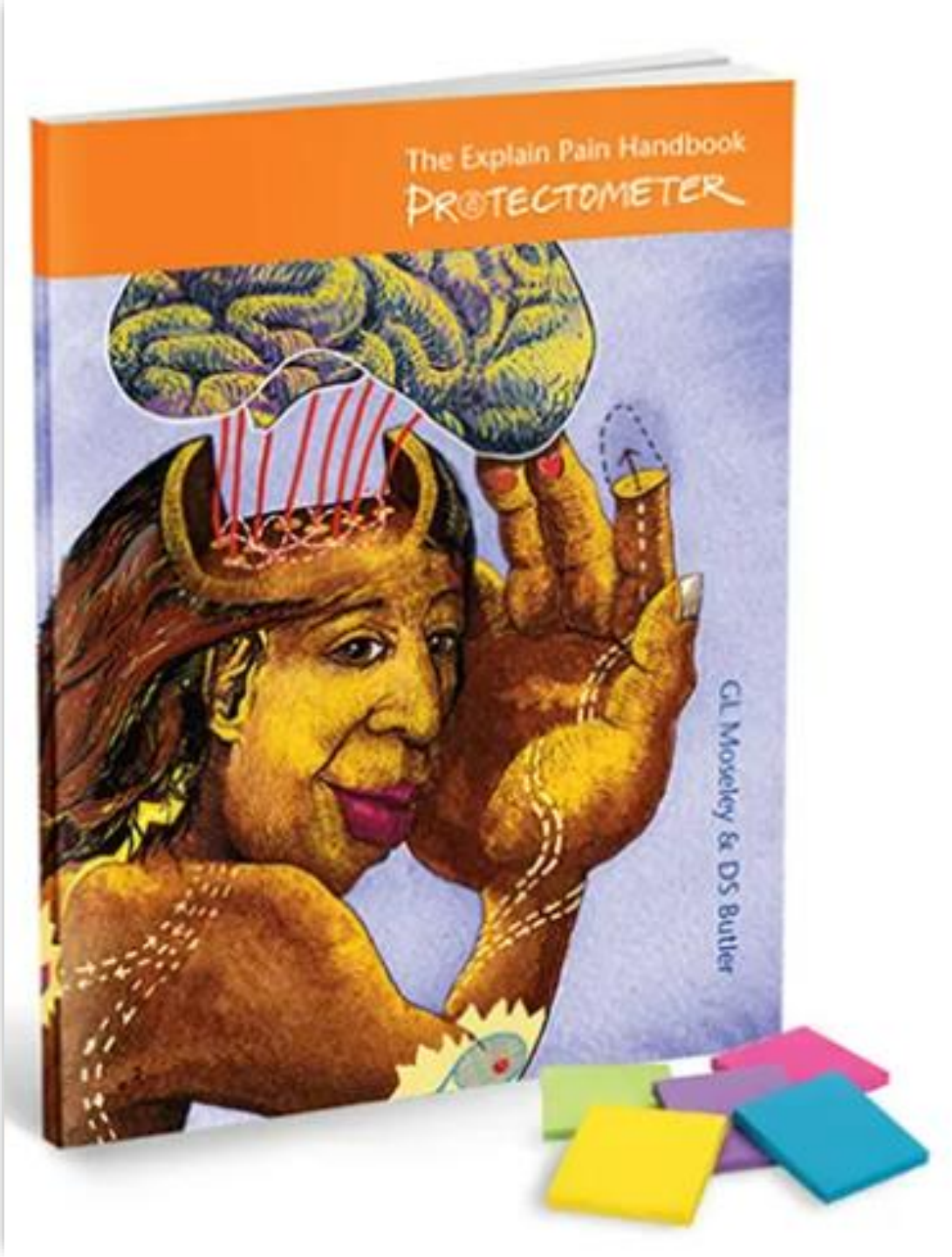
(10 pages but very complete assessment including activity levels, supports and mental health review)

Protectometer: The Explain Pain Handbook

- The Explain Pain Handbook: Protectometer is for anyone with persistent pain, who wants to understand the latest ideas in neuroimmune pain science – and use that knowledge to reduce their pain. Not just a book to read and forget, but a workbook to think about, write in and work through. The Handbook introduces the ‘Protectometer’ – a ground-breaking pain treatment tool.

- In this patient-targeted handbook, Dr David Butler and Professor Lorimer Moseley combine unique and original artwork with material that has been refined over the last twenty years. It helps you work out your pain aggravators and how to overcome them.

- Co-author Dr David Butler, says that “it is no longer acceptable that pain be just managed: we must expect that it can be treated, and sufferers can alter it themselves through education.”
- Protectometer: The Explain Pain Handbook - Pelvic Pain Foundation



Session 3

Time	Session name	Presenter	Delivery
2:00 pm	Physiotherapy Management of Prolapse, Urinary and Faecal incontinence; Physiotherapy Pelvic Health Service in MSHHS	Melanie Walkenhorst	Practical Demonstration ALL
2:15 pm	Hands-On Practical Demonstrations - Vaginal Pessaries - Speculum Use - Implanon Insertion - IUD Insertion - Pipelle Biopsy Demo - Endometrial Ablation Demo	Breakout Group Rotations	Facilitated groups Power Point Presentation & Forum Discussion
3:45 pm	Wrap Up CPD Discussion	Dr Kim Nolan ALL	ALL

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

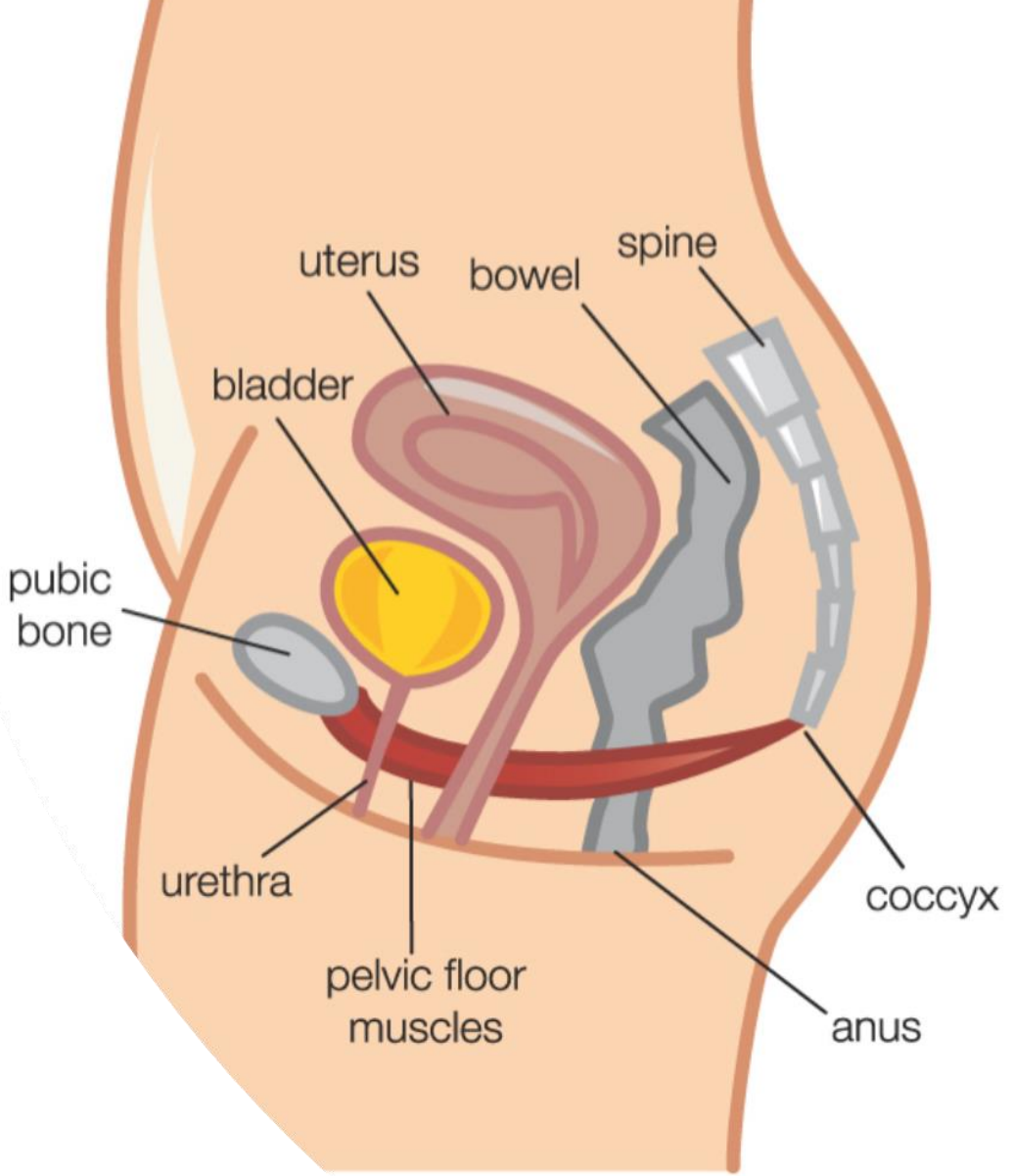
- Maternity Inpatient Unit (2hrs each weekday)

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.

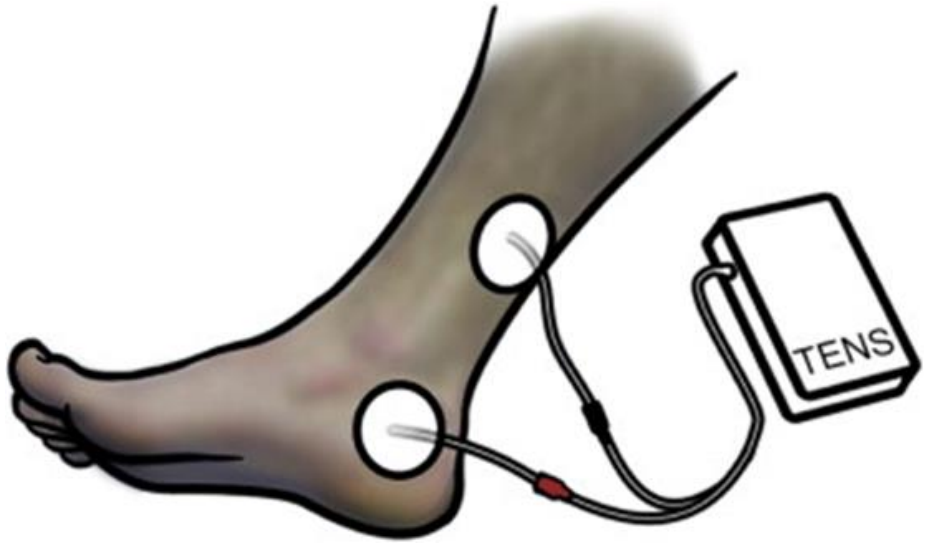
Physiotherapy Management Overview

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

Physiotherapy Management- Urinary dysfunction

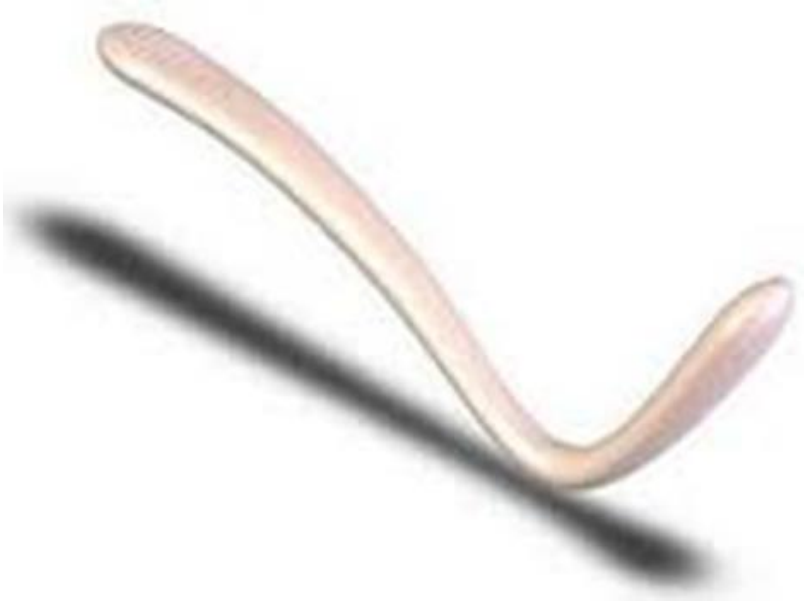
i.e. Urinary Incontinence, Voiding dysfunction, Bladder urgency

- 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

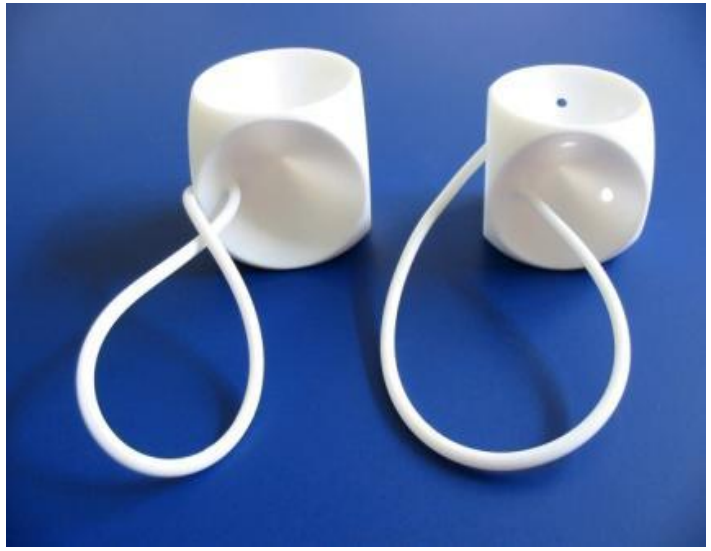
- Pain management
  - Pain neuroscience education
  - Downtraining
  - Biofeedback
  - Desensitisation
  - Soft tissue release
  - Neuromodulation

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



Images used with permission from Sayco Pty Ltd

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

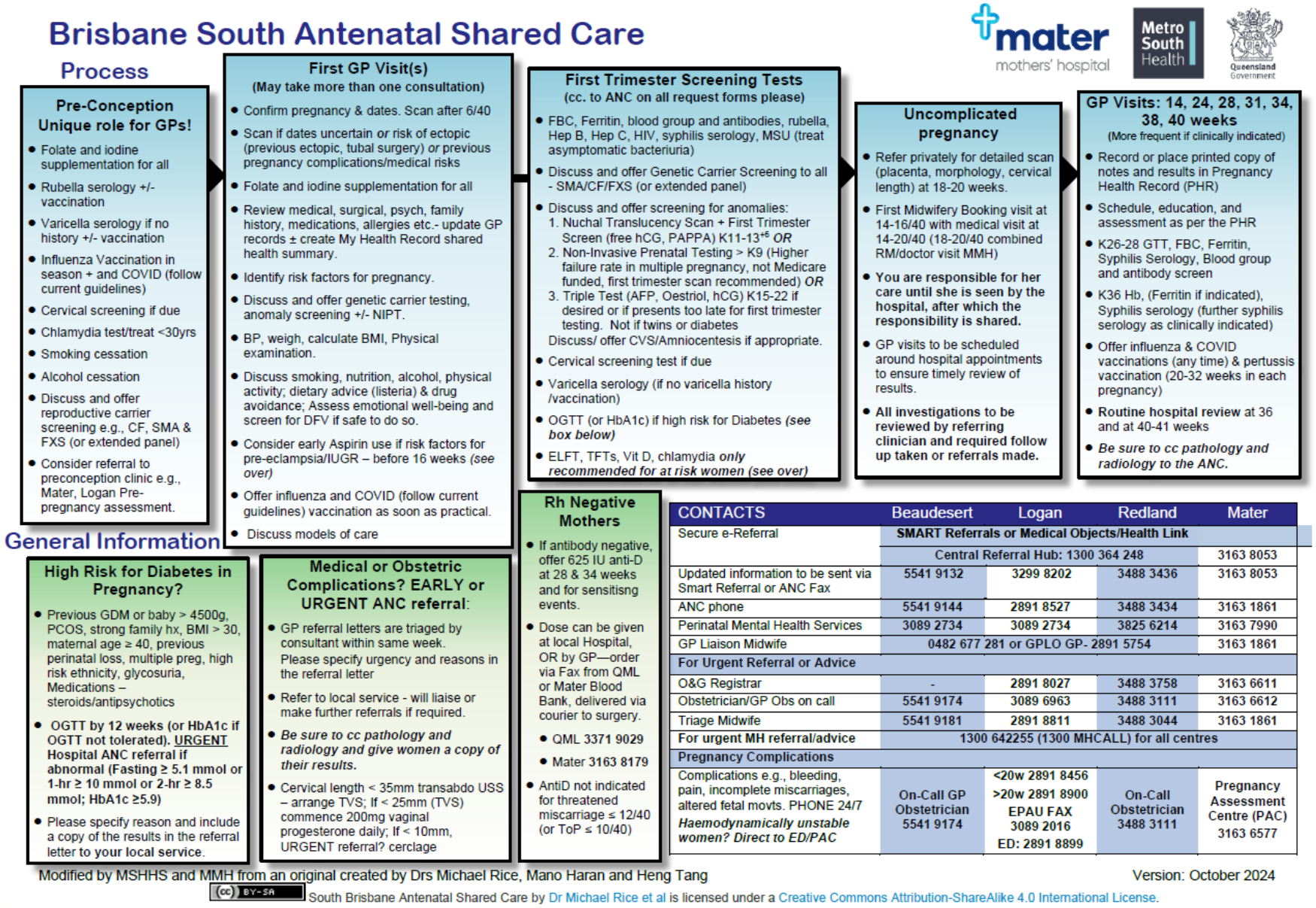
Session 3

Time	Session name	Presenter	Delivery
2:00 pm	Hands –On Practical Demonstrations - Speculum Use - Implanon Insertions - IUD Insertion - Pelvic Floor Muscle Anatomy - Pipelle Biopsy Demo - Endometrial Ablation Demo - Q & A with Gynaecologist	Breakout Group Rotations	Facilitated groups Power Point Presentation & Forum Discussion
3:45 pm	Wrap Up CPD Discussion	Dr Kim Nolan ALL	ALL

Breakout Groups

- IUD Insertions
- Speculum Examination Demonstration
- Pipelle Biopsy Demonstration
- Implanon Insertions
- Pelvic Floor Musculature Demonstration
- Your Gynaecology Questions Answered

Brisbane South Antenatal Shared Care Summary – October 2024



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 – chlamydia, ELFT, TSH/TFTs, Vit D, TORCH serology

- Chlamydia--test women < 30 years old and other high-risk women by first-pass urine PCR.
- ELFTs recommended for obese women (BMI > 30), hypertension or known or suspected renal or liver 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.
- 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 go up 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, 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 – 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 and pertussis vaccinations between 20-32 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 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 MAC 2891 8811
Redlands 3488 3111; Mater PAC 3163 6577

Late pregnancy complications (>20 weeks)

- Bleeding – can do spec exam but avoid PVE. Exclude cervical dilatation. Re-check placental site on original morphology scan, Rhesus negative mums need anti-D.
- Abdominal pain - can do spec exam but no PVE. Exclude cervical dilatation. Anti-D may be required for abruption.
- 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 2891 8811
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 and updated by Drs Kim Nolan, Wendy Burton, and Michael Rice – October 2024
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

- Thank you for your attendance today!
- Undertake Evaluation/Feedback – link to be forwarded – please let us know what we did well and what we could do better!
- As long as you are happy to have QFG have your contact details, CPD points can be logged by our QFG sponsor (6hrs EA + 2hrs RP)
- Please undertake the quiz sent through in next 2 weeks
- We will collect “Self-reporting of CPD points - Reviewing Performance” forms but please take a photograph.

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.
- We will ask for your permission for publication in the quiz that will be sent out in the next week.
- 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

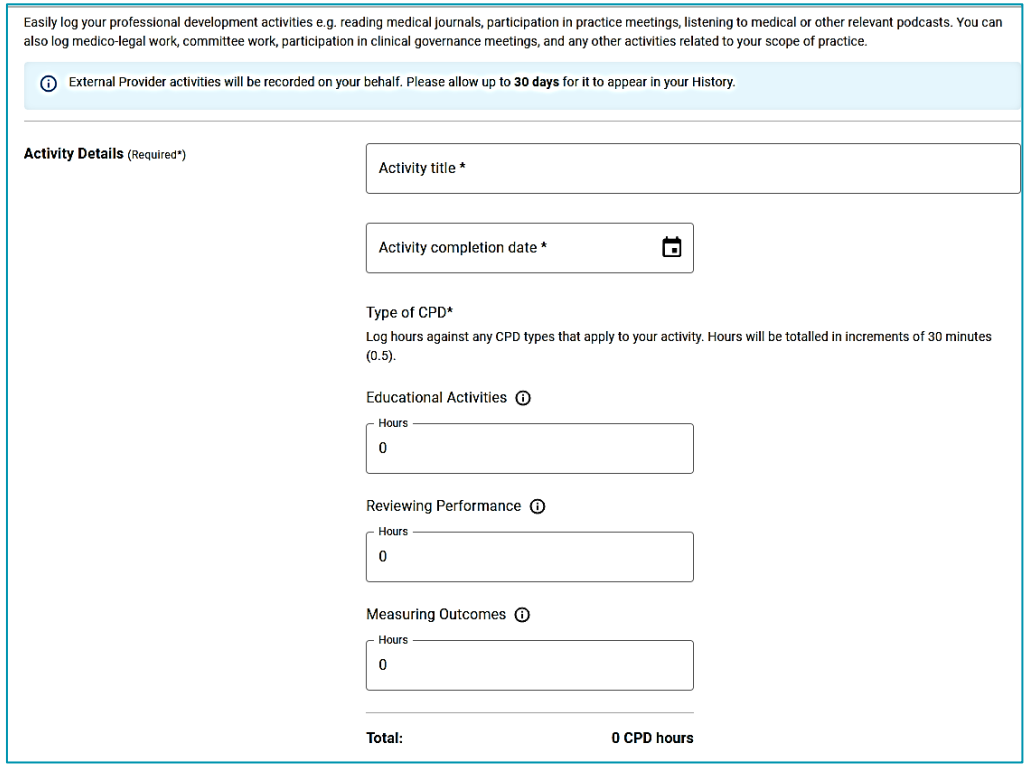
If you don't have any complications, you may choose to have most of your pregnancy care with your GP.

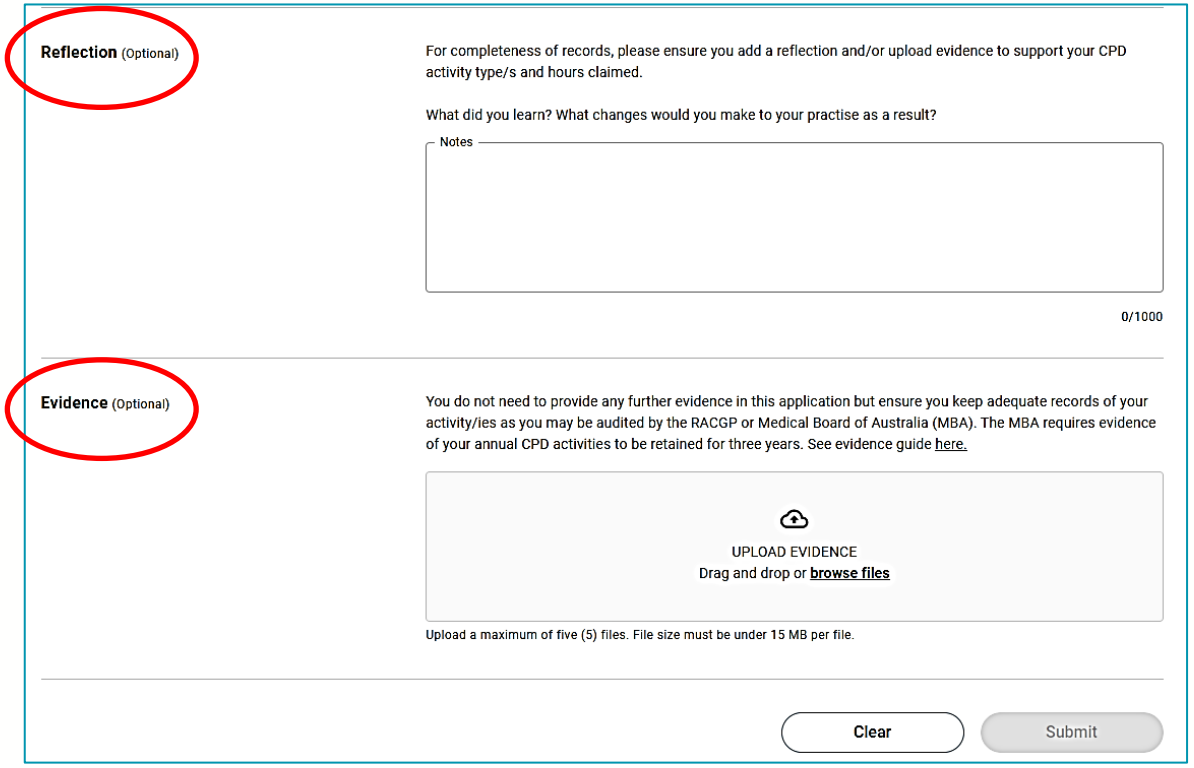
We'd still like to see you for the first booking appointment and again at 20, 36 and 41 weeks. If you develop any complications during pregnancy, your GP will refer you to us for ongoing care.

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.





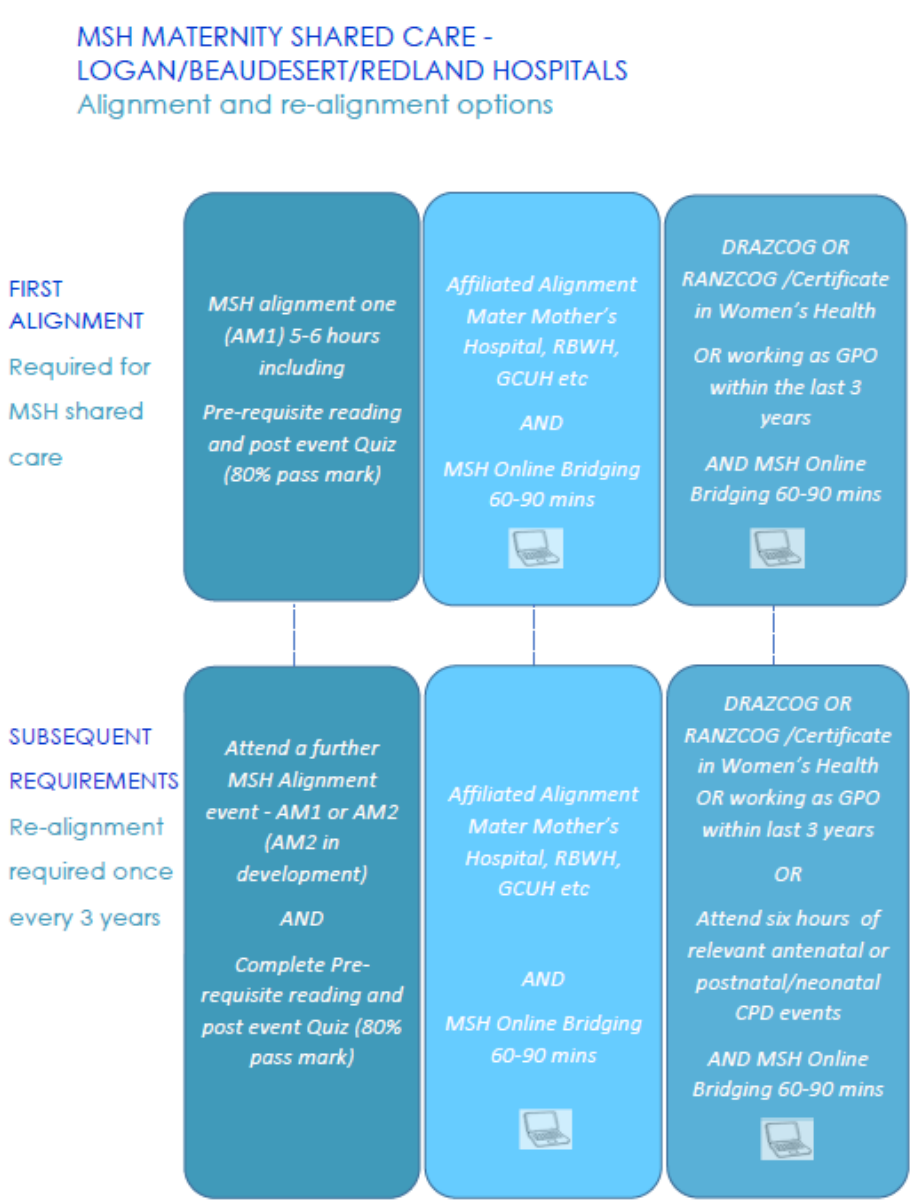
For GPs who hold DRANZCOG (now RANZCOG Associate) Qualifications – From 1st January 2024, when completing your mandatory Professional Development Plan (PDP) with your College CPD program, you are required to include goal(s)/activity(s) for women's reproductive health and provide evidence of completion of any activities in your College CPD portal. You are required to record eight (8) CPD hours of activities on your PDP relating to women's reproductive health, with a minimum of:

- Educational Activities (EA): 4 hours
- Outcome Measurement (OM): 2 hours
- Performance Review (PR): 2 hours

For self-reflection throughout case-based discussions

For CPD self-reporting - Reviewing Performance Gynae GP Education Day - Sat 26th October 2024

Red Case	**Green Case**	**Pink Case**
3 Things Learnt	3 Things Learnt	3 Things Learnt
1.	1.	1.
2.	2.	2.
3.	3.	3.
How will your patient care change?	How will your patient care change?	How will your patient care change?



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 (8hrs) and complete Knowledge Assessment (80% pass mark)
- 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 planned for early 2025 – Foundation Course

MSH Maternity Shared Care Online Bridging Programme

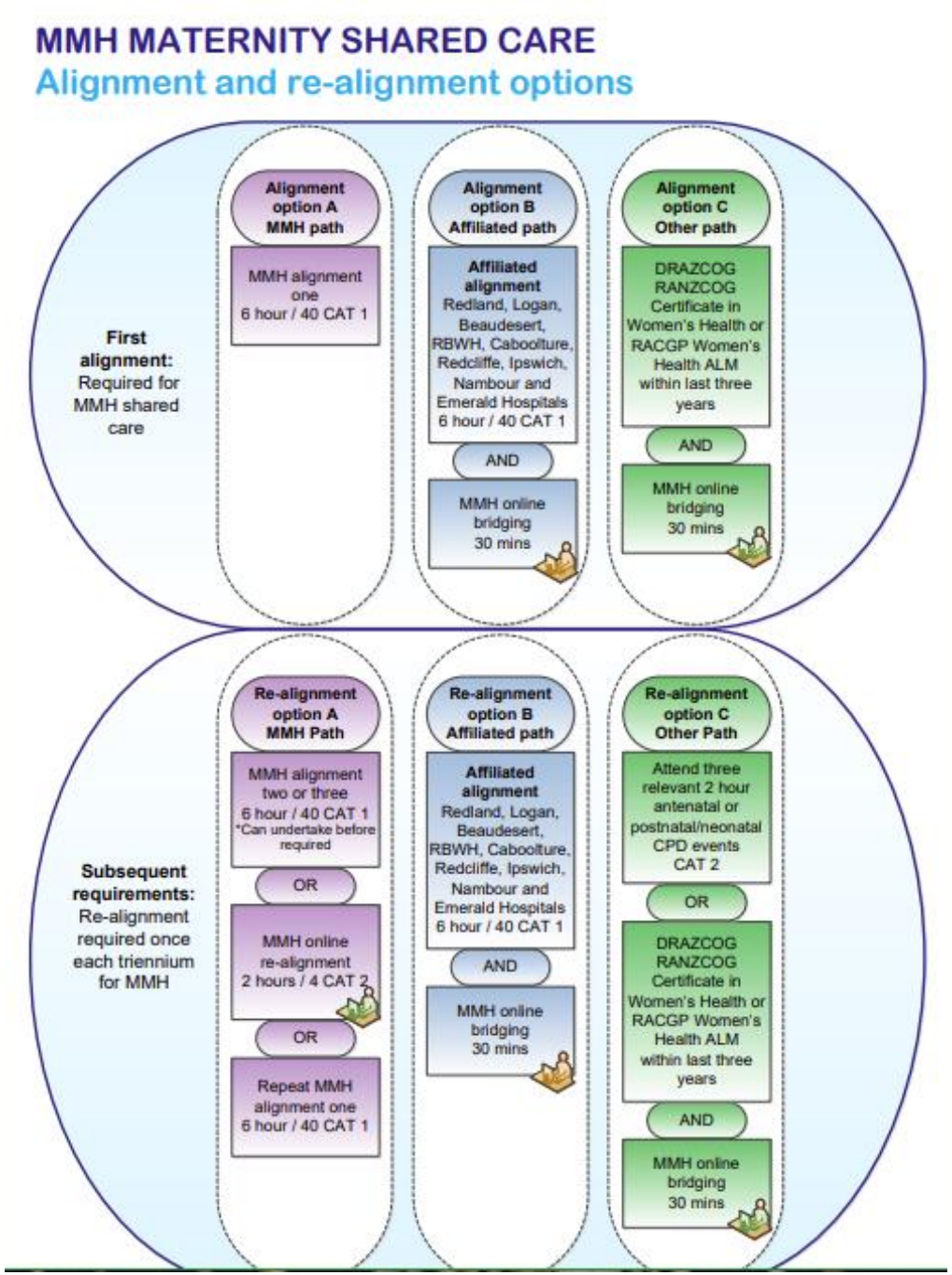
- Programme is delivered via an interactive online learning module including an exam/quiz to complete.
- Available to GPs who are currently aligned to Shared Care at MMH (or an alternative SEQ Alignment) and wish to align with MSH.
- Takes approximately 1- 1 ½ hours to complete.
- Once complete, GPs 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



Alignment Education – MMH – AM4

Upcoming event

Dear Doctors,

Mater Mothers' Hospital invites you to attend the upcoming Mater Mothers' Alignment 4.

About this event
This invitation is open to GPs who have already completed the MMH/ GP Shared Care Alignment 1 or an affiliated program.

Date: Saturday 2 November 2024

Time: 8am to 1pm

Location: Corbett Room, Level 1, Whitty Building, Mater, South Brisbane

Note: No cost to attend

CPD: 2 hours education activity
2.5 hours review of practice

Topics include:

- Early pregnancy loss
- Bereavement
- Physical and psychological birth trauma
- Trauma- informed care
- Neonatal examination
- Breastfeeding

The seminar is facilitated by a GP. The focus is on providing quality maternity shared care in the general practice setting, with up-to-date best practice information provided by Mater Mothers' staff specialists.

Event registration
Online registration is essential. If you wish to attend the education event on Saturday 2nd November please **register here**

Enquiries
If you have any questions about this event, please email **mscadmin@mater.org.au**

Need to have completed Alignment 1 at Mater or an affiliated event (MSHHS , Ipswich)

Perinatal Interprofessional Psychosocial Education for Maternity Clinicians (PIPE-MC)

To attend this workshop
Click register scan the QR code or visit:
https://bsphn.org.au/events/pipe_mc

phn BRISBANE SOUTH
An Australian Government Initiative

Perinatal Interprofessional Psychosocial Education for Maternity Clinicians (PIPE-MC)

Brisbane South PHN, is seeking Expressions of Interest from maternity clinicians to participate in a free training program (includes a one-day workshop and web-based resources) focused on perinatal mental health.

What is PIPE-MC
The PIPE-MC project is a simulation based, interprofessional training program designed to strengthen the capacity of health professionals to care for women with perinatal mental health concerns. A key focus of the program is to build skills in interprofessional collaboration. The development and evaluation of PIPE-MC has been funded by the Commonwealth Government Perinatal Mental Health Priority Grants.
The **PIPE-MC workshop will be offered as a one-day Face-to-face workshop**, limited to maximum of 15 interprofessional participants. A certificate of participation will be issued for CPD requirements.
Following the interactive workshops additional learning will be supported by online learning Moodle platform with access to augmented reality resources that build on skills practiced in the workshop and a community of practice forum. Additional certificate of participation will be issued for CPD requirements on completion of the modules. For General Practitioners this activity will include four hours of educational activities and two and a half hours of reviewing performance.

AUDIENCE: midwives, obstetricians, paediatricians, general practitioners, child & family nurses, allied health and mental health practitioners

LEARNING OUTCOMES:
At the end of the training participants will have skills and confidence to

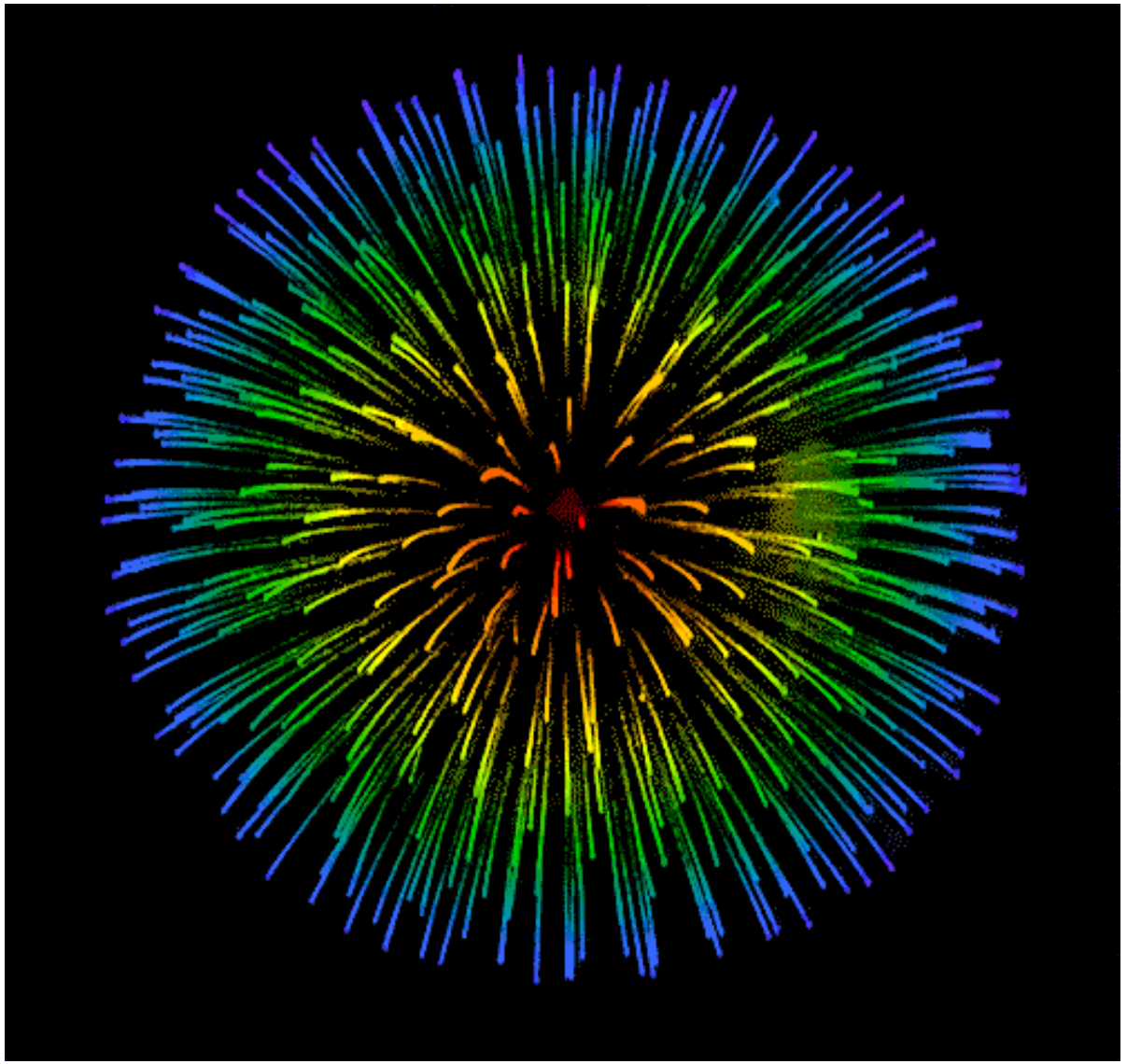
- identity, explore and clarify the concerns/worries and strengths/resources that women, their partners and family have
- identify and discuss referral pathways options with women and families
- explore and clarify the experience and support needs of fathers, non-birth parents and other family
- work in culturally sensitive ways including working with women and families from Indigenous and culturally and linguistically diverse (CALD) backgrounds including cultural and peer support workers
- participate in interprofessional communication and collaboration

DATE: Friday, 22 November 2024
TIME: Registration: 7.45 am
Start: 8:00 am
Finish: 4:30 pm
LOCATION: Brisbane South PHN, Ground Floor, Building 20, 2404 Logan Road Eight Mile Plains, 4113
COST: Free, Morning tea, lunch and afternoon tea will be provided.

To attend this workshop

Click here to register or scan the QR code or visit: https://bsphn.org.au/events/pipe_mc

First Floor, Building 20, Garden City Office Park, 2404 Logan Road, Eight Mile Plains QLD 4113
PO Box 6435, Upper Mt Gravatt QLD 4122 | ABN 53 151 707 765
T: (07) 3864 7555 or 1300 467 265 | bsphn.org.au



Enjoy the remainder of your weekend!