NHS

Herefordshire and Worcestershire

Herefordshire and Worcestershire Common Gynaecological Conditions Leading to Referral

Version 1.0 | April 2024

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This guidance is written with the aim of optimising referrals into the Gynaecology service. The correct patients should be referred to the right clinicians, with appropriate investigations performed and initial treatments tried.

This referral tool was arrived at after careful consideration of the evidence available including but not exclusively National Institute for Health and Care Excellence (NICE) recommendations, Royal College of Obstetricians and Gynaecologists (RCOG) guidelines and local embedded policies.

Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or carer.

Introduction

The Herefordshire and Worcestershire ICS Gynaecology Forum, which includes clinical representatives from Acute, Community and Primary Care are working together towards further developing our Gynaecological services and referral pathways.

As part of this work it also includes the following objectives:

- To promote evidence-based assessment and management of patients for the most common gynaecological conditions when accessing Herefordshire and Worcestershire NHS services.
- To build consistency across Herefordshire and Worcestershire, so all healthcare professionals understand the gynaecology referral and treatment pathways and can access the guidelines to support the needs of patients regardless of where they present.
- To support healthcare professionals by sharing learning and expertise across organisations in order to drive continuous development and implementation of high quality care pathways.
- To streamline the treatment pathway for those requiring gynaecological treatment, optimising their visit to secondary care, reducing the number of appointments, and shortening the time waiting for treatment.

The Herefordshire and Worcestershire ICS Gynaecology Forum are keen to promote the use of these pathways and patient information for the most common conditions that can cause patients to present to primary care. These include:

Pregnancy: Early Problems
Pregnancy: Nausea and Vomiting
Bleeding: Heavy Menstrual
Bleeding: Inter-Menstrual
Bleeding: Post Coital
Suspected Gynaecological Malignancy (including PMB)
Ovarian Cysts: General Information

Ovarian Cysts: Pregnancy Ovarian Cysts: Pre-Menopausal Ovarian Cysts: Post-Menopausal
Urinary Incontinence
Pelvic Organ Prolapse Subfertility
Endometriosis / Chronic Pelvic Pain
Menopause
Management of unintended pregnancy
Management of complex contraception

These guidelines have been developed using both national guidance such as NICE and RCOG publications, alongside local policies and protocols, and have been subject to clinical scrutiny. Whilst it is hoped that all healthcare professionals will acknowledge and embed this guidance within their clinical practice, it must be stressed that the guidance does not override the individual responsibility of the healthcare professionals to make decisions appropriate to the circumstances of the individual patient in consultation with them.

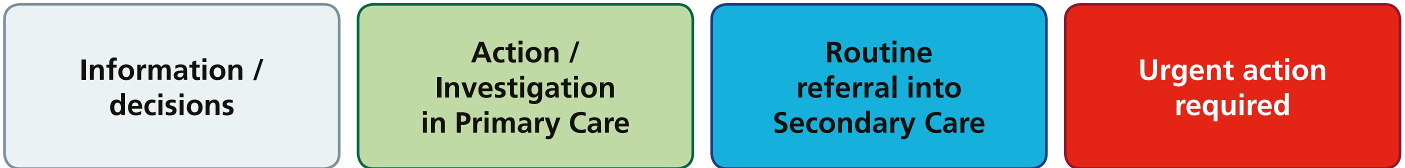
In addition to the guidance and pathways, the Advice and Guidance service is available to support primary care colleagues in their decision making and patient management.

Please Note -
Not all treatments or interventions detailed in the national guidance and advice leaflets may be commissioned locally, and therefore may not be available.

Document Guidance

We hope these guidelines will help support you and your colleagues in providing high quality care for gynaecology patients in Worcestershire. A list of abbreviations and definitions are available at the end of this document. All documents will be reviewed within three years of creation date.

Each pathway has been colour coded to assist with the identification of the care required as follows:



Within each pathway, there are also links to printable documents that provide additional information relating to each condition. These documents include Assessment tools, Patient Information, Referral Proformas, notes for GPs / Service Specifications and relevant Herefordshire and Worcestershire Clinical Commissioning policies.

When providing patients with information about their condition and the options for self-help, the free Ask NHS mobile app also provides useful supporting information. The App is available via the App Store and Google Play.

Please forward any feedback to Gynaecology services. Yours sincerely

GP:
Dr Louise Bramble (Worcestershire)

Gynaecology Consultants:
Mr Jon Hughes (Worcestershire)
Mr Angus Thomson (Worcestershire)
Miss Alex Blackwell (Worcestershire)
Mrs Amber Tahir (Herefordshire)
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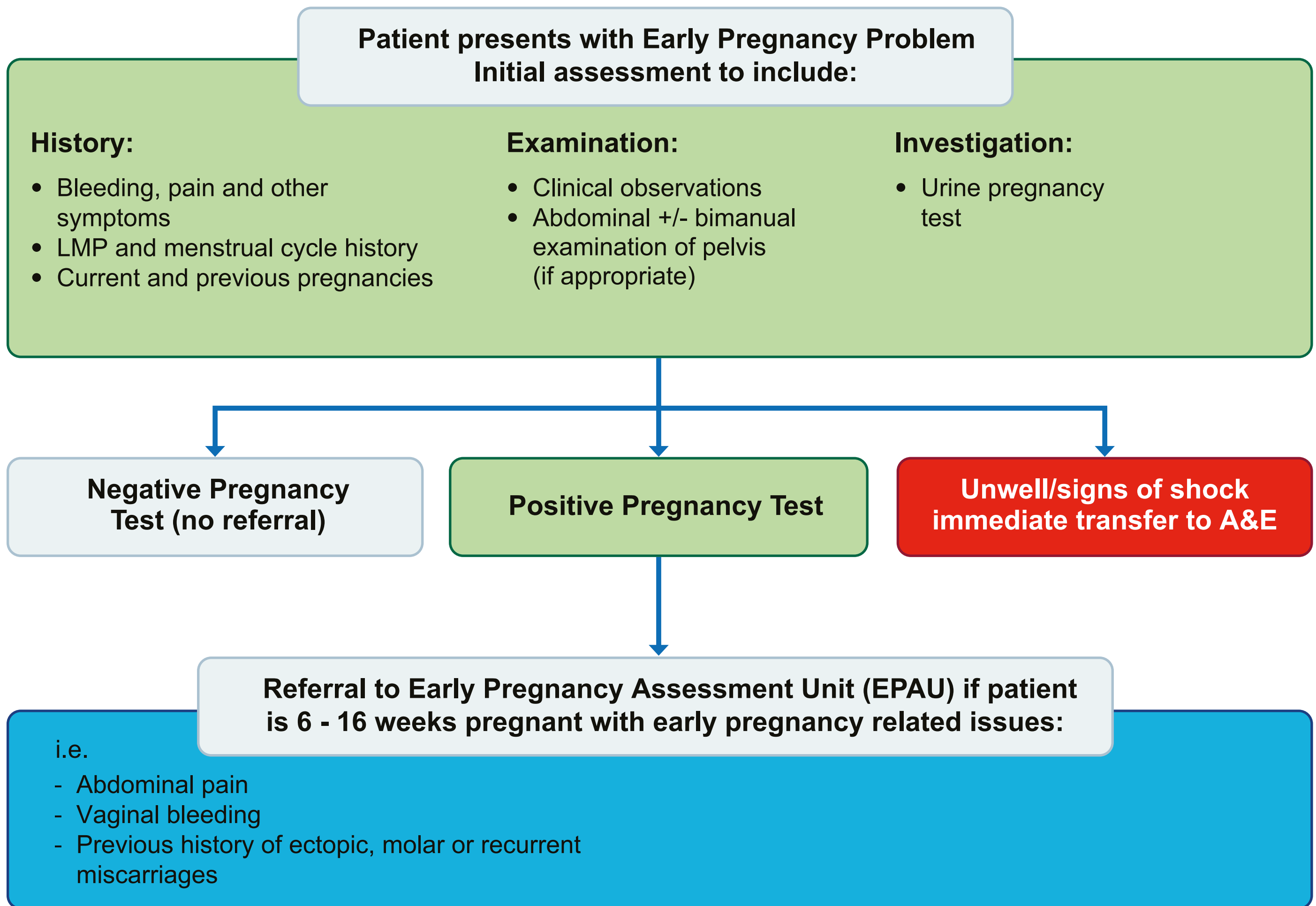
Version Control

Version	Update	Date
1	Previous versions of the Herefordshire and the Worcestershire documents have been merged to create version 1 of the Herefordshire and Worcestershire Common Gynaecological Conditions Leading to Referral	21/12/2023

1. Pregnancy: Early Problems



EPAU Clinic Details:

Worcestershire Royal Hospital	Alexandra Hospital	Kidderminster Treatment Centre	Herefordshire County Hospital
01905 733060 / 33803	**01527 503030 / 44714**	**01562 823424 / 55265**	**07717888736**
08:00 - 16:30 Mon - Fri	08:00 - 13:00 Mon - Fri	08:00 - 16:30 Mon - Fri	08:30 - 17:00 Mon - Fri

Out of Hours Details:

For urgent referrals outside these times contact the on call Gynaecology Registrar via switchboard on Worcestershire 01905 733060 / Herefordshire 01432 355444 . For stable patients who can wait for a scan / assessment then contact Emergency Gynaecology Assessment Unit (EGAU) (24/7) on Worcestershire 01905 761489 / Herefordshire 01432 355444. The Nurse will take the patient details and the EPAU Nurse will contact the patient the following working day.

Patient Information*:	Referral Proforma:	Local Guidance*:	National Guidance*:
Worcestershire Early Pregnancy Assessment Unit Herefordshire Early Pregnancy Assessment Unit	Not Required		Ectopic Pregnancy and Miscarriage Diagnosis - NICE Guidelines

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2. Pregnancy: Nausea and Vomiting

Patient presents with Nausea and Vomiting (<16 weeks pregnant)
Initial assessment to include:

History:

- LMP and menstrual cycle history
- Current and previous pregnancies
- Vomiting, tolerating food and drink
- Urinary symptoms and any other causes for vomiting
- Bleeding, pain and other symptoms
- Co-existing medical conditions e.g. diabetes

Examination:

- Clinical observations
- Assessment for dehydration
- Abdominal +/- bimanual examination of pelvis if appropriate
- Assess the Pregnancy-Unique Quantification of Emesis Index (PUQE)

Investigations:

- Urine analysis (checking for ketones or infection). Send MSU if appropriate
- Urine pregnancy test if not previously undertaken
- Consider blood tests if concern of hypokalaemia/thyrotoxicosis

Primary Care Management if patient stable, clinically well and < ketones (+)

- Rest
- Rehydration
- Avoid triggers
- Consider anti-emetics if intolerable
- Advise to seek medical review if deteriorates

Anti-emetics options: First line

- Cyclizine 50mg PO
- Prochlorperazine 5-10mg 6-8 hourly PO; 25mg PR daily
- Promethazine 12.5-25mg 4-8 hourly PO
- Chlorpromazine 10-25mg 4-6 hourly PO, 50-100mg 6-8 hourly PR

Further review in Primary Care to assess progress

Continue treatment if effective or trial alternative anti-emetics

If clinically unwell or ketones ≥(++)

Referral to Secondary Care if patient PUQE Index >13 unwell or ketones ≥(++)

Worcestershire:
Contact the registrar via switchboard on 01905 763333. For stable patients contact EGAU (working hours 24/7) on 01905 761489 for the nurse to take details of patient and arrange to contact the patient for review in EGAU (an appointment time will be given the same or following day depending on clinical situation).

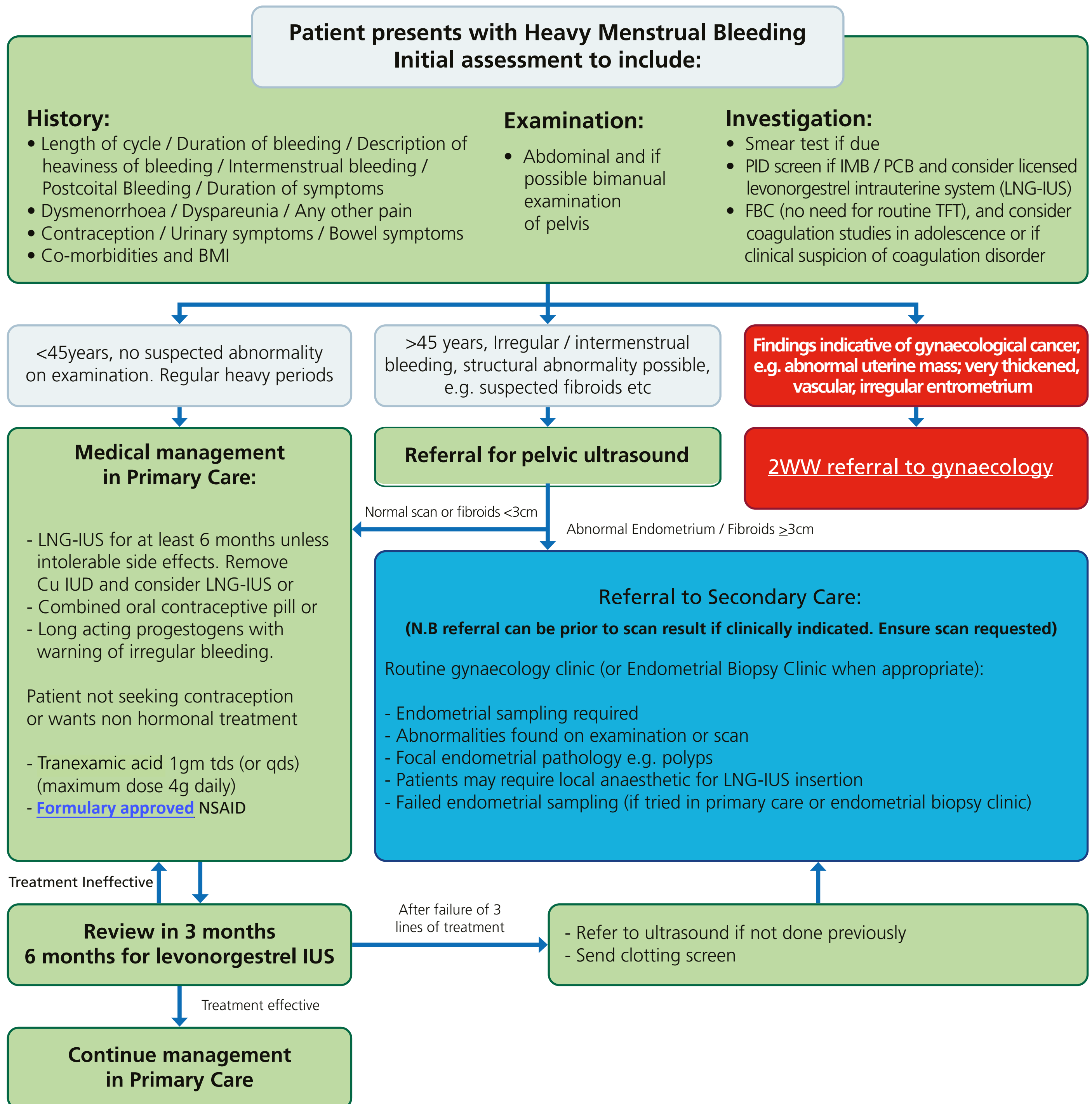
Herefordshire:
For urgent referrals contact the on call Gynaecology Registrar via switchboard on 01432 355444. (Bleep 712 Registrar / Bleep 711 for SHO)

NB: Inform patient that they may receive daily outpatient rehydration (on EGAU) or admission to hospital if clinically required.

Patient Information*:	Referral Proforma:	Local Guidance*:	National Guidance*:
RCOG - Hyperemesis Patient Information	**PUQE Index (Refer to page 24)** Refer to EMIS template for referral	N/A	RCOG Hyperemesis Guidelines

*Not all treatments or interventions detailed in the national guidance and advice leaflets may be commissioned locally, and therefore may not be available.

3. Bleeding: Heavy Menstrual



Patient Information*:	Referral Proforma:	Local Guidance*:	National Guidance*:
N/A	Referral form as on EMIS/TeamNet	Commissioning Policy Hormonal Contraception Management of Unscheduled Bleeding on HRT	NICE Guidance

*Not all treatments or interventions detailed in the national guidance and advice leaflets may be commissioned locally, and therefore may not be available.

4. Bleeding: Inter-menstrual

Patient presents with Inter-Menstrual Bleeding
Initial assessment to include:

History:

- Length of cycle / Duration of bleeding / Description of heaviness of bleeding / Nature of bleeding / Post coital bleeding / Duration of symptoms
- Dysmenorrhoea / Dyspareunia / Any other pain
- Contraception and sexual history
- Risk factors with cervical cancer
- Past obstetric and medical history, co-morbidities and BMI
- Urinary symptoms / Bowel symptoms

Examination:

- Abdominal, speculum and bimanual examination of pelvis (with visualisation of cervix)
- Looking for ectopy / polyp / contact bleeding / discharge / ulceration / warts / tumour / foreign body

Investigation:

- Cervical smear if due (and $\geq$25)
- Screen and test for infection including chlamydia
- Urine pregnancy test if appropriate

First line management in Primary Care:

- Treat infection if present
- NB Intermenstrual bleeding acceptable within first 3 months of hormonal treatment.
- Recent intermenstrual bleeding in patients taking hormonal contraception and Cu IUD follow FSRH Guidance on unscheduled bleeding.
- Consider alteration of hormonal contraception

Routine General Gynaecology clinic referral if:

- Cervical polyp
- Bleeding cervical ectropion
- All patients >45
- Patients <45 with persistent (more than 3 consecutive months) symptoms and/or risk factors for endometrial cancer

Routine Colposcopy referral if: IMB/ PCB with a history of high grade
- CGIN at any time or high grade CIN (CIN2/3) within the last 10 years

*Request urgent ultrasound scan at time of referral

Urgent/2WW referral if:

- Clinical suspicion of cervical cancer (irrespective of smear status)

Persisting symptoms/not responding to treatment
Refer to routine general gynaecology clinic

Risk factors for cervical cancer:

- Smoking / immunosuppression
- Age at 1st sexual intercourse / early 1st pregnancy
- Number of partners
- History of sexually transmitted infections, especially chlamydia/herpes
- More than 3 full term pregnancies
- Low socio-economic background/ poor diet

Patient Information*:

Worcestershire Colposcopy Leaflet

Herefordshire Colposcopy Leaflet

Referral Proforma:

Referral Proforma

Local Guidance*:

New Management of Unscheduled Bleeding (HRT)

National Guidance*:

FSRH Guidance Unscheduled Bleeding

BGS Guidelines

*Not all treatments or interventions detailed in the national guidance and advice leaflets may be commissioned locally, and therefore may not be available.

5. Bleeding: Post Coital

Patient presents with Post Coital Bleeding
Initial assessment to include:

History:

- Length of cycle / Duration of bleeding / Description of heaviness of bleeding / Nature of bleeding / Post coital bleeding / Duration of symptoms
- Dysmenorrhoea / Dyspareunia / Any other pain
- Contraception and sexual history
- Risk factors with cervical cancer
- Past obstetric and medical history, co-morbidities and BMI

Examination:

- Abdominal, speculum and bimanual examination of pelvis (with visualisation of cervix)
- Looking for ectopy / polyp / contact bleeding / discharge / ulceration / warts / tumour / foreign body

Investigation:

- Cervical smear if due (and ≥25)
- Screen and test for infection including chlamydia
- Urine pregnancy test if appropriate

Medical management of intermenstrual or post-coital bleeding in Primary Care:

- Treat infection if present
- If no risk factors for cervical cancer and examination normal observation is acceptable within first 3 months
- For recent unscheduled bleeding in patients taking hormonal contraception and copper IUCD follow FSRH Guidance on unscheduled bleeding.
- Consider alteration of hormonal contraception

Routine Gynaecology clinic referral if:

- Cervical polyp
- Bleeding cervical ectropion
- All patients ≥45
- Patients <45 with persistent (more than 3 consecutive months) symptoms and/or risk factors for endometrial cancer

Routine Colposcopy referral if:

- IMB/PCB with a history of high grade CGIN at any time or high grade CIN (CIN2/3) within the last 10 years

Urgent / 2WW referral to Colposcopy if:

- Clinical suspicion of cervical cancer (irrespective of smear status)

PMB / 2WW referral if:

- Post menopausal

Post Menopausal Bleeding:

Post Menopausal Bleeding is defined as bleeding after >12/12 since last period
(NB – Unscheduled bleeding on HRT is now managed as per the **Unscheduled Bleeding on HRT Pathway.**

Risk factors for cervical cancer:

- Smoking / immunosuppression
- Age at 1st sexual intercourse / early 1st pregnancy
- Number of partners
- History of sexually transmitted infection, especially chlamydia / herpes
- More than 3 full term pregnancies
- Low socio-economic background/poor diet

Persisting symptoms / Not responding to treatment. Refer to Routine General Gynaecology clinic

Patient Information*:	Referral Proforma:	Local Guidance*:	National Guidance*:
Worcestershire Colposcopy Leaflet Herefordshire Colposcopy Leaflet	Refer to EMIS template for referral	Management of Unscheduled Bleeding on HRT	FSRH Guidance Unscheduled Bleeding BGS Guidelines

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6. Suspected Gynaecological Malignancy (inc. PMB)

Patient presents with Unscheduled Bleeding or symptoms of other suspected gynaecological malignancy Initial assessment to include:

History:

- Presenting history
- Nature and duration of bleeding (see definition of PMB below)
- Abdominal symptoms
- Urinary symptoms / Bowel symptoms
- Other medical history, Co-morbidities and BMI

Examination:

- Abdominal and bimanual / speculum examination of pelvis

Investigations:

- Cervical smear test if due (and >25)
- Swabs for infection if appropriate

See Notes for GPs / Service Specifications below

2WW referral to Gynaecology
(NB: This will include a scan, thus no separate referral is required)

Post Menopausal Bleeding (PMB):

Post Menopausal Bleeding is defined as bleeding after >12/12 since last period
(**NB** – Unscheduled bleeding on HRT is now managed as per the **Unscheduled Bleeding on HRT Pathway**.

Risk factors for endometrial cancer:

- Age
- BMI
- Type 2 diabetes
- Smoking
- Nulliparity
- Use of Tamoxifen
- Hypertension
- Early menarche/late menopause
- Previous endometrial hyperplasia

Risk factors for cervical cancer:

- Smoking / Immunosuppression
- Age at 1st sexual intercourse / early 1st pregnancy
- Number of partners
- History of sexually transmitted infection especially chlamydia/herpes
- More than 3 full term pregnancies
- Low socio-economic background/poor diet

Patient Information*:

Worcestershire Colposcopy Leaflet

Herefordshire Colposcopy Leaflet

Referral Proforma:

Referral Proforma

Local Guidance*:

Management of Unscheduled Bleeding on HRT

National Guidance*:

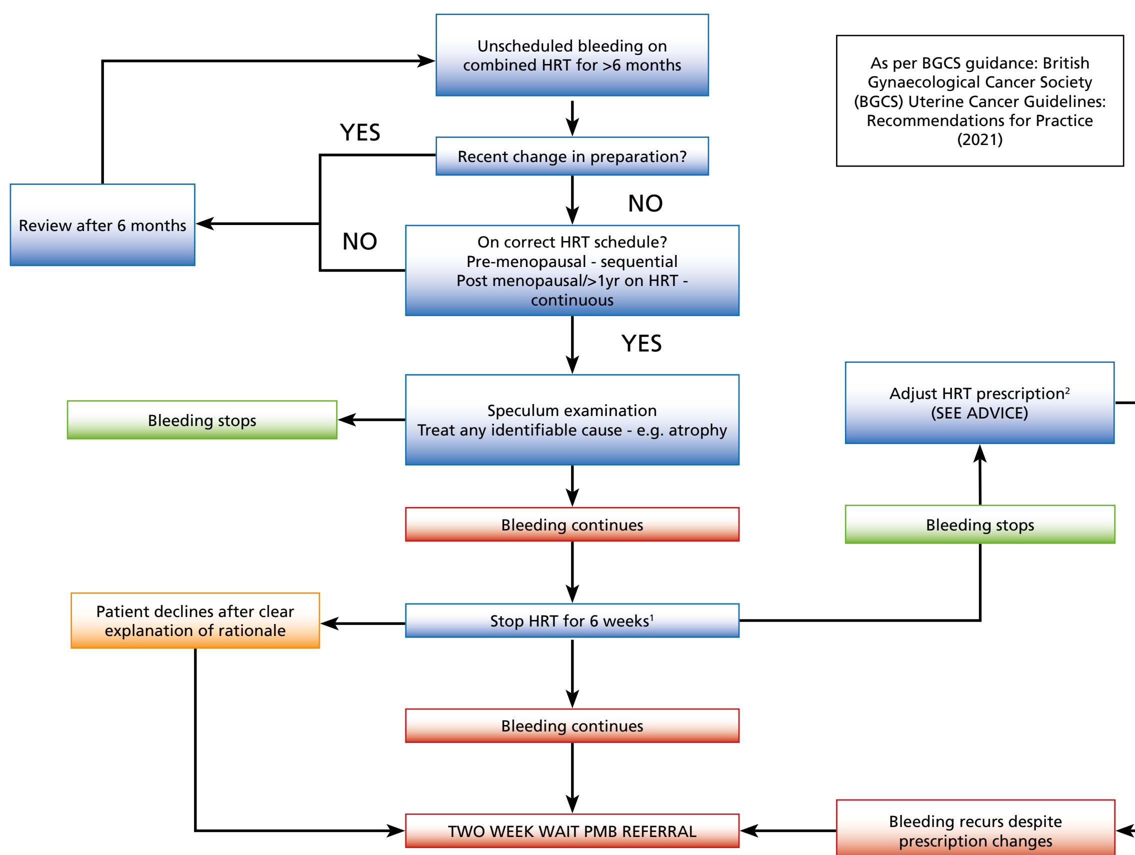
*Not all treatments or interventions detailed in the national guidance and advice leaflets may be commissioned locally, and therefore may not be available.

6a. Unscheduled Bleeding on HRT

The most common symptom of women with endometrial cancer is postmenopausal bleeding. For patients not on hormone replacement therapy (HRT) this will necessitate an urgent, two-week wait referral.

It is common for HRT to cause unscheduled bleeding and current guidance from the British Gynaecological Cancer Society recommends that women on HRT with unscheduled bleeding should initially have a speculum examination, and, if necessary, have their HRT discontinued for six weeks to establish whether the HRT regime is causing the bleeding. Those with persistent bleeding following HRT withdrawal must then be referred to a rapid access gynaecology clinic, without re-starting their HRT, to exclude endometrial pathology.

Those patients found to have unscheduled bleeding due to their HRT should have their regimes modified to minimise the risk of further bleeding once their HRT is restarted. See flowchart and guidance below:



Patient Information*:	Referral Proforma:	Local Guidance*:	National Guidance*:
N/A	Refer to EMIS template for referral	N/A	BMS

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6a. Unscheduled Bleeding on HRT

Sequential HRT Changes:

- Check patient compliance
- Align with normal menstrual cycle
- Ensure progestogen is last 12-14 days of cycle
- Increase progestogen e.g. If using Utrogestan® 200mg, increase to 300mg ('Off-label' dose)
- Switch to different progestogen/product e.g. Elleste Duet® 1mg to Femoston® 1/10
- Increase duration of progestogen intake e.g. 21 days out of 28-day cycle ('Off-label' use)
- Consider Mirena® coil

Continuous HRT Changes:

- Check patient compliance
- Aim for lowest dose preparation
- Increase dose of progestogen e.g. if using Utrogestan® 100mg, increase to 200mg ('Off-label' dose)
- Change progestogen
- Change product e.g. Elleste Duet Conti® to Femoston Conti®
- Add in Utrogestan® (oral progestogen associated with lower bleeding risk than topical)
- Consider Mirena® coil
- Consider reverting to sequential HRT

For further advice/evidence see: BMS Guidance- Progestogens & Endometrial Protection

References

1. British Gynaecological Cancer Society Uterine Cancer Guidelines: Recommendations for Practice. 2021
2. Management of bleeding problems with HRT, Journal of Family Planning and Reproductive Health. 2002 28(4): 182-184
3. https://thebms.org.uk/wp-content/uploads/2021/10/14-BMS-TfC-Progestogens-and-endometrial-protection-01H.pdf

Patient Information*:	Referral Proforma:	Local Guidance*:	National Guidance*:
N/A	Refer to EMIS template for referral	N/A	BMS

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7. Ovarian cysts - General Information

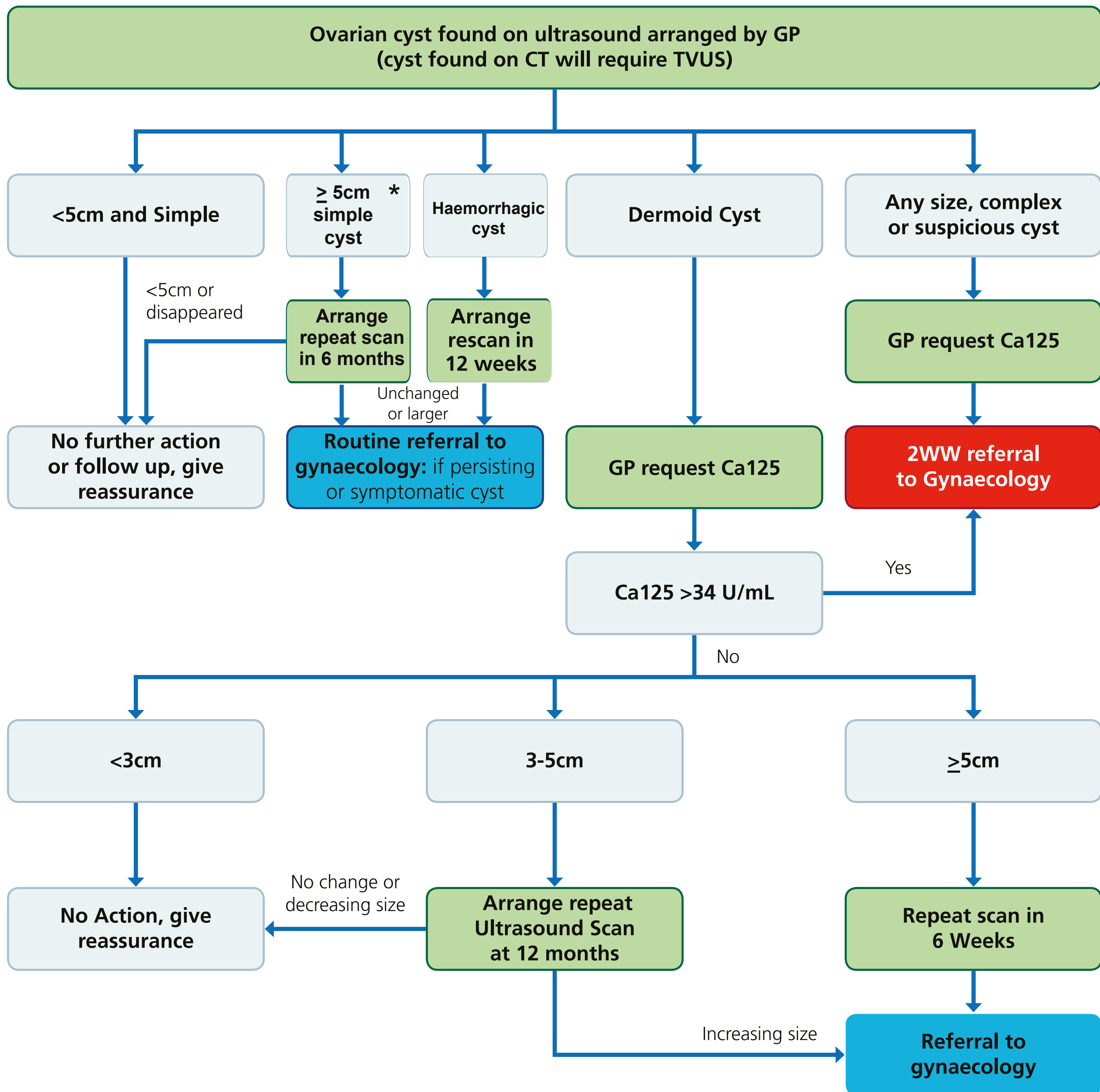
Knowing the options

When a scan report is received indicating an ovarian cyst, there are only three options for further management which are to repeat, to reassure, or to refer (either routine or urgent). Most scan reports will include management advice based on the following pathways. When reviewing a scan result, patients should be managed according to their fertility status: Pregnant, Pre-menopausal, and Post-menopausal.

Ultrasound features can be broadly divided into benign (reassuring) or malignant (suspicious) as shown in the table below:

Benign / More Reassuring Features (Simple)	Malignant / Suspicious Features
Unilocular cysts	Multilocular cysts
Diameter <10cm	Diameter ≥10
Minimal solid component <7mm	Solid component ≥7mm
Smooth outline	Irregular outline
Acoustic shadowing indicating Dermoid	Features not indicative of Dermoid
No blood flow	Prominent blood flow
No / Little fluid	Ascites or significant fluid

8. Ovarian cysts: Pre-menopausal



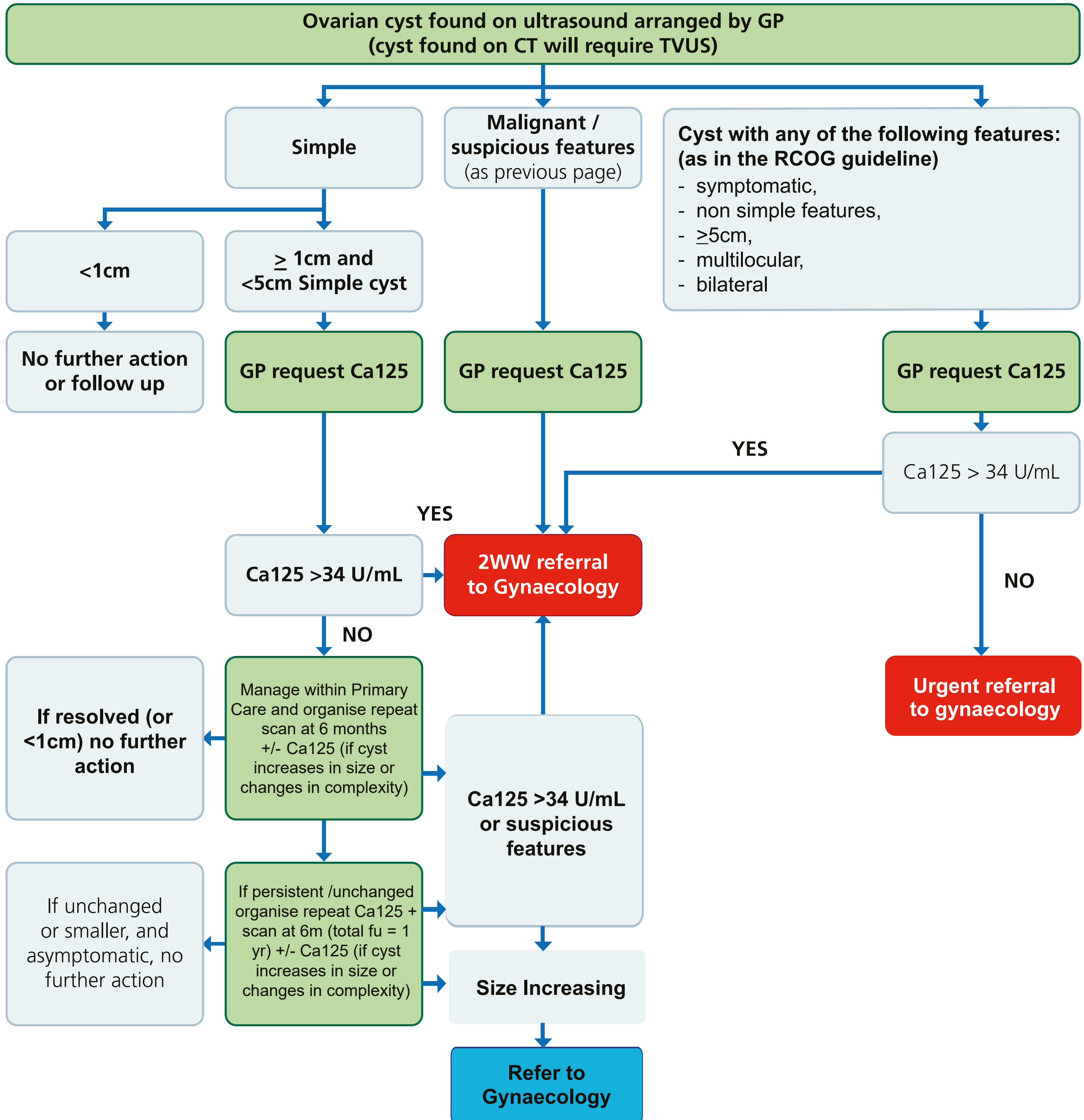
* If pregnant repeat scan in 4 weeks and refer to antenatal clinic to review results

Please utilise the Advice and Guidance service for any patient-specific queries

Patient Information*:	Referral Proforma:	Local Guidance*:	National Guidance*:
RCOG Pre-Menopause Patient Information	Referral Proforma	2WW and PMB GP Notes	RCOG Pre-menopausal Cyst Guidelines

*Not all treatments or interventions detailed in the national guidance and advice leaflets may be commissioned locally, and therefore may not be available.

9. Ovarian cysts: Post-menopausal



Please utilise the Advice and Guidance service for any patient-specific queries

Patient Information*:	Referral Proforma:	Local Guidance*:	National Guidance*:
N/A	Referral Proforma	2WW and PMB GP Notes	RCOG Ovarian Cysts - Post Menopause

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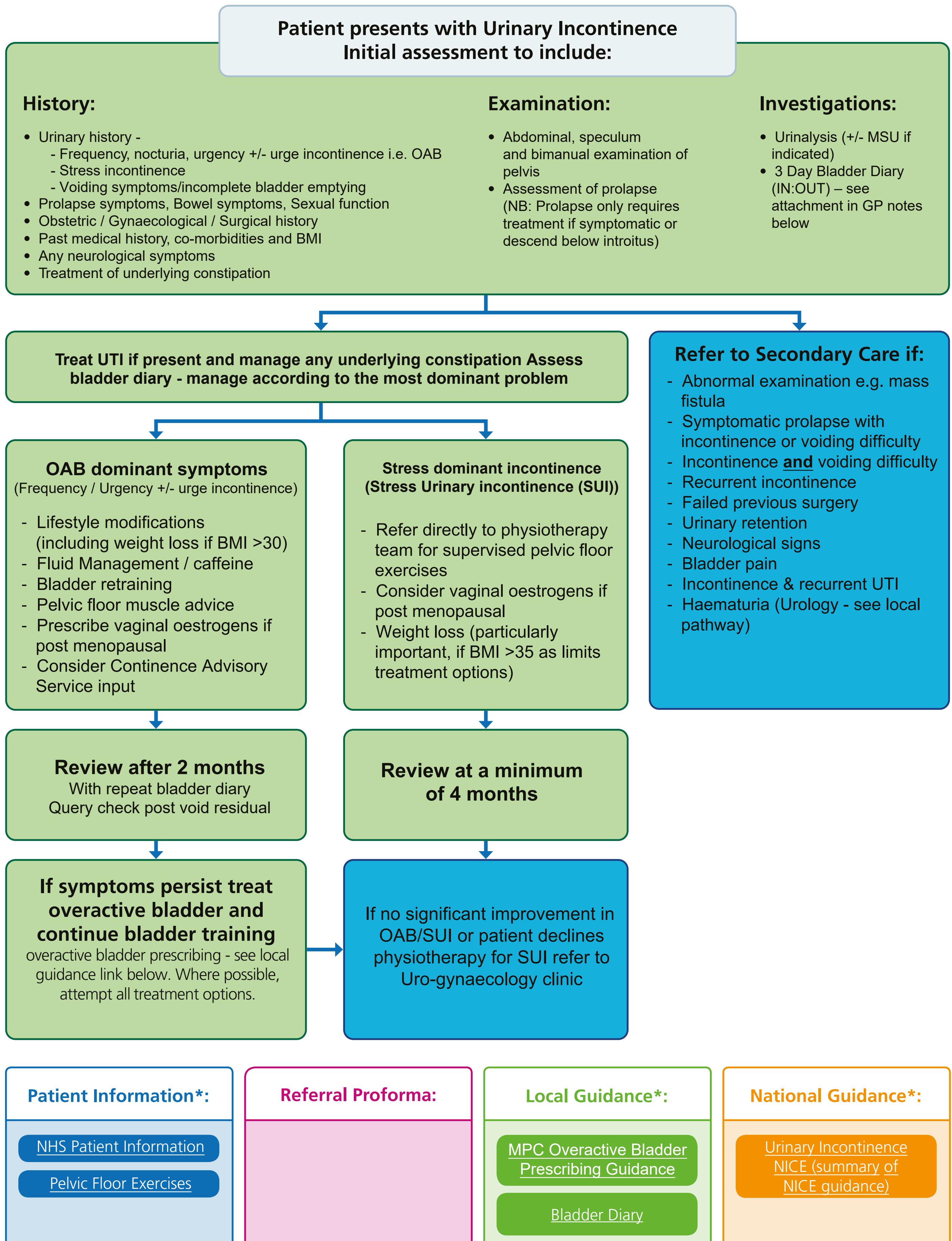
10. Urinary Incontinence/Overactive Bladder (OAB)



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11. Pelvic Organ Prolapse

Patient presents with Pelvic Organ Prolapse
Initial assessment to include:

History:

- Prolapse history (mechanical symptoms, lump, bulge, obstruction, pressure, back ache)
- Urinary history (frequency, nocturia, urgency, stress incontinence, urge incontinence, voiding symptoms)
- Bowel symptoms (constipation, digitation / splinting, faecal incontinence, tenesmus)
- Sexual Function (sexual activity, dyspareunia, obstruction, incontinence)
- Obstetric / Gynaecological / Surgical history
- Past medical history, co-morbidities and BMI

Examination:

- Abdominal, speculum (Sims preferable) and bimanual examination of pelvis – to exclude pelvic masses.
- Assessment of prolapse **(NB: Prolapse only requires treatment if symptomatic or beyond introitus.)**
- Consider rectal examination.

Investigations:

- Urinalysis (+/- MSU if indicated)
- Consider 3 Day Bladder Diary (IN:OUT) - see attachment in GP notes below
- Consider USS for post void residual
- Consider FBC, U&Es if severe prolapse with risk of ureteric obstruction

Conservative management in Primary Care:

- Weight loss, address co-morbidities and precipitants - **please be aware we will not generally offer prolapse surgery if the BMI is >40. Only conservative measures will be employed, except in unusual circumstances after MDT discussion**
- Manage constipation
- Prescribe vaginal oestrogen if atrophy, recurrent UTI's
- If mild symptoms then offer direct referral to physiotherapy for pelvic floor muscle exercises (for a minimum of 4 months), see patient information below
- If Post Void Residual required to exclude high residuals - consider referral to Continence Advisor
- **Offer and fit a simple ring pessary in primary care if appropriate** (Worcestershire - see Locally Enhanced Service) - if successful patient will require 4-6 monthly changes and speculum assessment
- **Always** prescribe concurrent vaginal oestrogen with a pessary (unless contraindicated)

Follow up assessment after 3 months

- Continue management if effective i.e. pelvic floor exercises, ring pessary (with oestrogen)
- Consider referral for physiotherapy or continence advisor if ineffective

Refer to Secondary Care - UROGYNAECOLOGY ONLY if:

Patient is willing to consider surgery with:

- **Persistent symptomatic prolapse and/or**
- **Prolapse beyond introitus**

NB: Give patient NHS/British Society of Urogynaecology (BSUG) Patient information on "Surgery for Prolapse" (see below). Where appropriate the patient should be made aware that they may need to engage in a weight loss and exercise programme.

Other indications for referral:

- Failed physiotherapy
- Failed ring pessary
- Want to consider alternative pessary
- Concurrent urinary incontinence/retention issues
- Concurrent bowel emptying difficulty
- Concurrent problems with recurrent UTIs

Patient Information*:

Surgery for Prolapse

Pelvic Floor Exercises

Referral Proforma:

Refer to Blueteq form

Local Guidance*:

Bladder Diary

Commissioning Policy

National Guidance*:

NICE.org

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12. Fertility

Please advise patients if they have private IVF they will forfeit their NHS cycle (if eligible)

Patient presents with Subfertility Initial assessment to include:

History:

- Length of time trying to conceive
- Past gynaecological, obstetric and medical history (both partners)
- Menstrual cycle, previous surgeries and infections
- Other medical history, Co-morbidities and BMI (both partners)
- Previous pregnancies and children (both partners)

Examination:

- As determined by symptom history

Investigations:

- Chlamydia screen

Advise:

- To have intercourse 2-3x a week
- **BMI >30** will reduce chance of conception, increase the risk of miscarriage, fetal anomalies and pregnancy complications

Initial advice and management in Primary Care

- Preconception advice leaflet (see attachment below)
- Advise folic acid 400mcg per day (GP please prescribe folic acid 5mg if BMI >29 or PMH of diabetes, epilepsy, personal or family history of NT defects, Coeliac disease, sickle cell), and Vitamin D (10mcg OD)
- Smoking cessation advice (both partners)
- Weight loss, where appropriate – exercise and dietary advice (both partners). Emphasise BMI, see BMI calculator below
- **If female BMI >35: referral will not be accepted**, as we do not recommend further investigations (HSG) or give ovulation induction drugs (clomid). This is due to increased risks in pregnancy to mother and baby and the decreased chance of success. Please refer to dietician and Tier 3 weight management clinic
- Lifestyle advice: alcohol, caffeinated beverages, tight underwear, complementary therapy, prescribed, over-the-counter & recreational drug use, occupation
- **If oligo/amenorrhoea** - please prescribe medroxyprogesterone acetate (MPA) 10mg TDS for 7 days to induce a withdrawal bleed. Please ensure patients have at least 4x a year to reduce the risk of endometrial hyperplasia
- In women with PCOS and raised BMI - consider Metformin (500mg OD, increase after 2 weeks to BD then TDS if tolerated or 850mg if modified release). There is also good anecdotal evidence that myo-inositol 2g BD can help regulate cycles (OTC)

Criteria for consideration of Secondary Care referral when:

1. Failure to conceive after regular unprotected sex for a period of not less than 1 year (or 6 months in patients aged 36+), in the absence of known reproductive pathology
   For single people and same sex couples, the equivalent evidence would constitute 6 cycles of unstimulated artificial insemination **OR**
2. Known or suspected reproductive issue diagnosed in either partner i.e. irregular cycles, PCOS, abnormal SA or undescended testis (refer without delay) **OR**
3. Refer immediately if: i) Patient/host aged over 39 years ii) History of chronic viral infection (HIV, HBC, HCV) iii) Patient awaiting treatment that may result in infertility (see Cryopreservation policy)

IMPORTANT: NHS (charges to oversees visitors) regulations: patients who have paid the Immigration Health Surcharge, and those who are not ordinarily resident, will be charged for access to our fertility services. Please ensure your patient is aware prior to referral and ask them to contact the overseas patient department at Worcestershire Acute to confirm whether they are eligible (tel: 07706990803 or email: wah-tr.acsenquiries@nhs.net)

Investigations prior to referral

- Pelvic ultrasound scan (please add indication i.e. 1yr primary subfertility, irregular cycle, query PCOS to ensure not rejected by radiology)
- Female blood tests on day 2-5 of cycle (any time if amenorrhoeic) to include: FSH/LH, prolactin, TSH, testosterone, Rubella
- Progesterone on day 21, only if regular 28 day cycle i.e. 7 days prior to period (do not do if irregular cycle)
- Semen analysis (see form below) - please do not delay referral to wait for the results

Refer to hospital fertility clinic using proforma below (not available in Wye Valley)

Eligibility Criteria For Assisted Conception Treatment In Tertiary Care (e.g. IVF/ICSI)

All patients meeting the subfertility clinic referral criteria should be referred, but please make them aware that they may not be eligible for all NHS treatment unless below criteria met:

- Female Age between 18 and 39 inclusive
- Female BMI between 19 and 29 inclusive; Male BMI 29 or less (where male factor infertility identified)
- No living children (of any age), including adopted children or children from the current or any previous relationship
- Non Smoking Couple for a minimum period of 6 months (this may include use of stop smoking products if clinically appropriate)
- No Prior Assisted Conception Treatment (NHS or private)
- No Prior Sterilisation

Patient Information*:	Referral Proforma:	Local Guidance*:	National Guidance*:
Fertility patients preconception advice leaflet Fertility Journey booklet BMI target calculator	Referral form as on EMIS/TeamNet	Assisted Conception Policy Semen analysis GP information Semen analysis request	NICE CG156 Fertility Problems

*Not all treatments or interventions detailed in the national guidance and advice leaflets may be commissioned locally, and therefore may not be available.

13. Endometriosis / Chronic Pelvic Pain

Patient presents with Chronic Pelvic Pain
Initial assessment to include:

History:
- Pain - Duration, location, radiation, severity, alleviating factors, medications
- Menstrual - dysmenorrhoea, dyspareunia, dyschezia, other pelvic pain, hormonal treatments
- Bladder - frequency, nocturia, pain with full bladder, relief with micturition
- Bowel - altered bowel habit, constipation, diarrhoea, abdominal bloating, relief with defecation
- Other past medical, gynaecological and obstetric history, BMI
- Desire for pregnancy (currently or in future)

Examination:
- Abdominal and bimanual examination (if possible), including assessment of pelvic floor muscle tenderness

Investigations:
- Consider pelvic ultrasound
- Consider screen for pelvic infections / UTI
- Consider CA125

Based on symptoms and examination – decide upon the likely underlying diagnosis (see GP notes below)

Mainly:
- Dysmenorrhoea +/- menorrhagia
- Cyclical pelvic pain
- Dyschezia
- Cyclical bladder pain
- Lethargy

Examination:
- Pelvic Floor tenderness
- Vaginismus
- Unable to perform digital exam
- Nodularity
- Pelvic fixation
- Pelvic tenderness

Mainly:
- Abdominal pain
- Bloating (abdominal)
- Pain relieved by defaecation
- Altered bowel habit (>3/day<3/week – BO)
- Altered stool form
- Pain worse on eating
- Lethargy

Examination:
- Abdominal tenderness
- PR? Constipated

Possible IBS / Gastroenterology cause

Mainly:
- Urinary frequency
- Urinary urgency
- Nocturia
- Pelvic/bladder pain
- +/- urge/stress incontinence

Examination:
- Vaginal wall tenderness
- Pelvic floor tender
- Fixation/ nodularity

Possible Painful Bladder Syndrome / Urological Cause

Mainly:
- Dyspareunia
- Pain worse at movement improved with rest
- Non cyclical abdominal/lower back pain
- Pelvic/abdominal/ lower back
- Vaginal wall tender
- Pelvic floor tender / spasm of PC / RR muscles

Possible Musculoskeletal Pain

Mainly:
- Non cyclical pain / constant pelvic / abdo
- Not improved following surgical intervention / simple analgesia
- Lethargy
- Pain not limited to pelvic

Possible Neuropathic Pain

Refer to appropriate clinics

Not trying to conceive:
- Commence regular NSAIDs **and/or**
- Commence hormonal treatment (COCP / POP / LNG-IUS)
- Review 3/12 - if treatment not effective request Pelvic USS

Trying to conceive:
- Commence NSAIDs during menstruation
- Consider fertility investigations (see pathway)
- Review 3/12 - if treatment not effective request Pelvic USS

Refer to general Gynaecology Clinic if treatment not effective

Patient Information*:

RCOG Chronic Pelvic Pain

NHS Endometriosis

Referral Proforma:

Refer to EMIS template for referral

Local Guidance*:

Managing Neuropathic Pain

National Guidance*:

NICE diagnosis and management

NICE Guidelines

*Not all treatments or interventions detailed in the national guidance and advice leaflets may be commissioned locally, and therefore may not be available.

14. Menopause

Patient presents with symptoms of the menopause, initial assessment to include:

History
- Duration of symptoms
- Menstrual cycle
- Co-morbidities
- Surgical history
- Medications / over the counter

Symptoms due to low oestrogen
- Vasomotor (hot flushes/night sweats)
- Psychological (mood, brain fog)
- Urogenital atrophy (vaginal dryness, recurrent UTIs, frequency)
- Altered sexual function (low libido)

Lifestyle changes:
- BMI and weight advice
- Smoking: earlier menopause (by 1-4yrs)
- Alcohol: worsens hot flushes
- Diet & exercise
- Recommend CBT/mindfulness

Risk factors
- Personal or family history of VTE or breast cancer
- BMI >30
- Any contraindication (CI) to HRT

- **Perimenopause:** time of irregular periods and symptoms leading up to the menopause
- **Menopause:** no period for >12m, average 51yrs
- **Postmenopausal:** 12m after the last period
- **Early menopause:** <45yrs of age, raised FSH
  - **Primary Ovarian Insufficiency (POI):** <40yr, irregular periods & 2x raised FSH >25 iu/l 4wks apart (ESHRE)

Hormones
- Uterus/residual endometriosis post-hysterectomy: oestrogen, and progesterone for protection
- Hysterectomy: oestrogen only
- +/- vaginal oestrogen and testosterone

Regime
- Perimenopausal / having periods: cyclical / sequential (daily oestrogen with progesterone for >12d of cycle)
- Postmenopausal (no periods): continous combined (daily oestrogen and progesterone)

Type / route
- Recommend Transdermal if any risk factors (BMI >30 or personal / family history of VTE) OR
- Oral (increased risk of VTE, avoid if BMI >30)

Risks:
- VTE (if oral)
- Breast cancer
- Stroke

Benefits:
- Symptom control
- Protective: CVS and bones
- Limited evidence regarding: bowel cancer

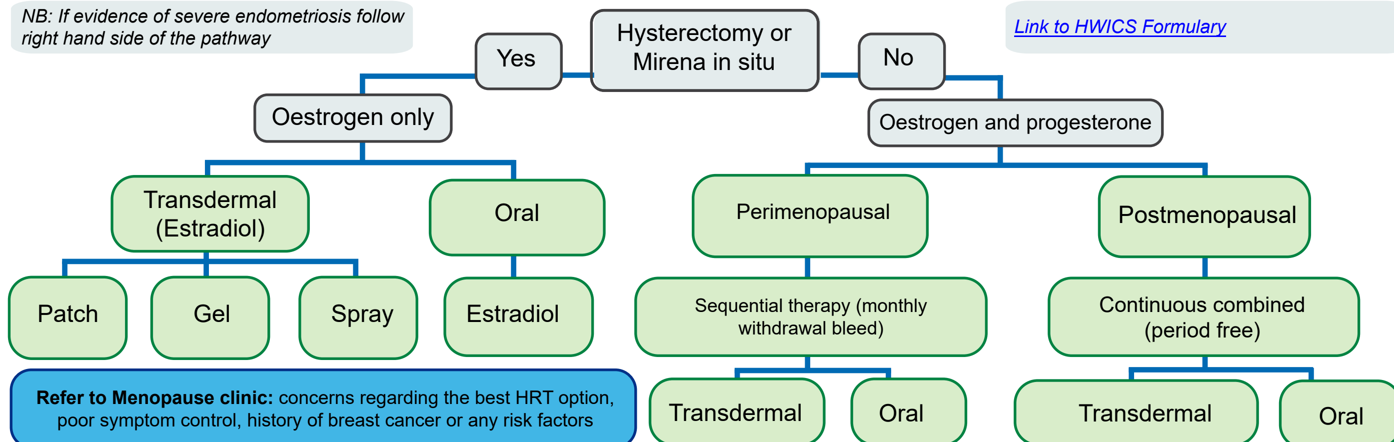
- Ensure no contraindications (CI)*
- Discuss risks & benefits
- Start lowest dose to control symptoms, reassess at 3m
- Change to continuous combined at 54yrs if not done previously

***CI to HRT:** pregnancy / breast feeding, undiagnosed PVB, Endometrial cancer/hyperplasia, active liver disease, active / recurrent VTE, active / uncontrolled atrial disease.

Relative CI: History breast or ovarian cancer, fibroids, atypical ductal hyperplasia, gallbladder dis, thrombophilia

NB: If evidence of severe endometriosis follow right hand side of the pathway

Link to HWICS Formulary



Bleeding problems:
- Common in the first 3m
- >3m report to GP
- >6m - stop HRT for 6weeks
- If bleeding continues – refer as 2ww
- If bleeding stops and symptoms:
  – recommence on changed regime
  – increase progesterone dose or decrease oestrogen dose

Non-hormonal alternatives:
- Clonidine (licensed)
- Off-label for vasomotor symptoms: anti-depressants i.e. SSRIs (citalopram), and Oxybutynin
- No long-term benefits as oestrogen is not being replaced

Vaginal preparations:
- Estradiol 10mcg pessaries
- Estriol 0.1% cream
- Nocte for 2weeks and then 2x a week long-term

Non-hormonal (purchased OTC):
1. Vaginal lubricant (i.e. SYLK or YES)
2. Vaginal moisturiser (i.e. Replens)

History of Breast cancer:
- HRT not first line
- Try non-hormonal alternatives
- Vaginal oestrogen creams: use Estriol as less potent

If on Tamoxifen: can use topical creams. These are contra-indicated if on aromatase inhibitors.

HRT is NOT contraception, and must be taken in addition if required. The POP progesterone is not licensed for endometrial protection. The mirena coil is

Caution: Evening primrose, St Johns wart, Black cohosh, Isoflavones – not regulated, can interfere with other medications

Testosterone
- Tostran 2% or Testogel
- Not-licensed for women
- Consider if post menopausal and symptoms of hypoactive sexual desire disorder and a low marker of testosterone
- See GP Prescribing Policy below

Patient Information*:
Menopause Patient Booklet

Referral Proforma:
Refer to EMIS template for referral

Local Guidance*:
PM Bleeding Guideline
Testosterone Leaflet
Testosterone Guideline

National Guidance*:
WHC: Breast Cancer Risk Chart
BMS website
NICE CG 23 Menopause

15: Management of Unintended Pregnancy

Patient presents with unintended pregnancy

History
- LMP
- Bleeding
- Pain
- Other medical problems/history
- Has considered all choices:
  - continuing
  - adoption
  - abortion

Examination
- Abdominal examination to check if uterus palpable per abdomen

Investigation
- Urine pregnancy test

Positive Pregnancy Test
otherwise well

Patient decides to continue with pregnancy

Patient unsure about abortion

If patient would like an abortion discuss options available:
- Medical (up to 9+6 weeks)
- Surgical (up to 23+6 weeks)

Patient requests medical management (up to 9+6 weeks)

Patient requests surgical management <10 weeks

Patient requests surgical management >10 weeks

Refer to Integrated Sexual Health (WISH) / Bluebell Suite
Pregnancy Advisory Service (PAS) /
Early Medical Abortion Service
0300 123 1731 option 4 whcnhs.worcesterpass@nhs.net

Advise patient to self refer to British Pregnancy Advisory Service (BPAS) / MSI Reproductive Choices.
NB must speak to WISH first for authorisation number, if under 9 weeks

British Pregnancy Advisory Service	MSI Reproductive Choices	WISH Service
(BPAS) 03457 304030	**0345 300 8090**	**0300 123 1731 option 4**
Mon-Fri 7am-6pm	7am-6pm	whcnhs.worcesterpass@nhs.net
Sat 8am-4pm Sun 9.30am - 2.30pm		

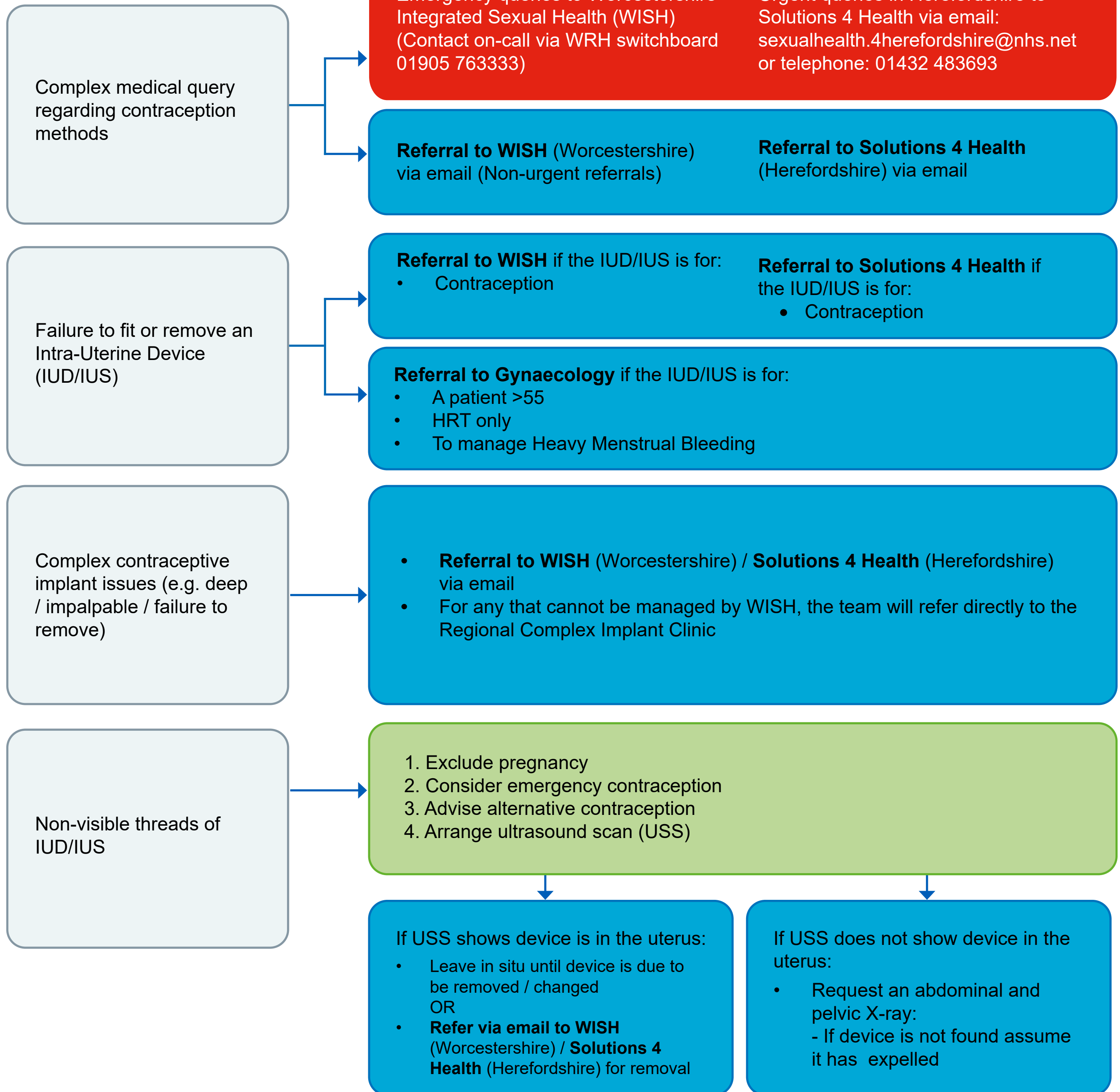
Patient Information:
N/A

Referral Proforma:
Refer to EMIS proforma

Local Guidance*:
N/A

National Guidance*:
COVID-19 infection and abortion care
Abortion Care Guidance

16: Complex Contraception Referral



Sexual Health Clinic Emails: Referrals will be triaged and added to the waiting list

Arrowside, Redditch
WHCNHS.arrowmail@nhs.net

Aconbury, Worcester
WHCNHS.wishaconbury.worcester@nhs.net

Kidderminster
Kidderminster.sexualhealth@nhs.net

Solutions 4 Health, Herefordshire
sexualhealth.4herefordshire@nhs.net

References and Resources

- National Institute for Health & Clinical Excellence - NICE Pathways www.nice.org.uk
- Royal College of Obstetricians & Gynaecologists - www.rcog.org.uk/en/patients
- Worcestershire Acute Hospitals NHS Trust. Local Trust pathways for a range of Gynaecological conditions
- Wye Valley NHS Trust
- Other NHS organisations guidelines and protocols

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Acknowledgements

Refer to individual Herefordshire and Worcestershire documents for authors and contributors

Latest Document (Herefordshire and Worcestershire 2024) -
Gynaecology Team, Worcestershire Acute Hospitals NHS Trust
Gynaecology Team, Wye Valley NHS Trust
Herefordshire and Worcestershire Primary care representatives
Herefordshire and Worcestershire Integrated Care Board representatives
Solutions 4 Health, Herefordshire
Worcestershire Integrated Sexual Health, Herefordshire and Worcestershire Health and Care Trust

Governance

Date	Document reviewed by
Feb 2024	HW ICS Medicines and Prescribing Sub-Committee
Feb 2024	HW ICS Clinical Assurance Sub-Committee

Glossary

2WW	Two-week wait	LMP	Last menstrual period
BD	Twice daily	LNG-IUS	Levonorgestrel Intrauterine System
BMI	Body Mass Index	MSU	Mid-stream urine
BSUG	The British Society of Urogynaecology	NICE	National Institute for Health and Care Excellence
Ca125	Cancer antigen 125	NSAIDs	Non-steroidal anti-inflammatory drugs
CIN	Cervical Intra-epithelial Neoplasia	NT	Neural tube
CGIN	Cervical Glandular Intra-epithelial Neoplasia	OD	Once daily
COCP	Combined Oral Contraceptive Pill	PCB	Post coital bleeding
CT	Computed Tomography	PCOS	Polycystic Ovary Syndrome
Cu IUD	Copper Intrauterine Device	PID	Pelvic inflammatory disease
EGAU	Emergency Gynaecology Assessment Unit	Po	Oral
EPAU	Emergency Pregnancy Assessment Unit	POP	Progesterone only pill
ESHRE	European Society of Human Reproduction and Embryology	PMB	Post-menopausal bleeding
FBC	Full Blood Count	RCOG	Royal College of Obstetricians and Gynaecologists
FSH	Follicle-stimulating hormone	Rx	Prescription
FSRH	Faculty of Sexual and Reproductive Health	Tds	Three times daily
HRT	Hormone Replacement Therapy	TFT	Thyroid function test
HSG	Hysterosalpingogram	TSH	Thyroid stimulating hormone
IBS	Irritable Bowel Syndrome	TVUS	Transvaginal ultrasound scan
IMB	Inter-menstrual bleeding	U&E	Urea and electrolytes
IUCD	Intrauterine Contraceptive Device	UG	Urogynaecology
IUS	Intrauterine System	USS	Ultrasound scan
LA	Local Anaesthetic	UTI	Urinary tract infection
LARC	Long-acting reversible contraception	Urol	Urology
LH	Luteinizing Hormone	VTE	Venous thromboembolism
LLETZ	Large loop excision of the transformation zone	WISH	Worcestershire Integrated Sexual Health Service