Common Gynaecological Conditions Leading to Referral

Version 1.0 | October 2018

Produced on behalf of:
NHS Redditch and Bromsgrove Clinical Commissioning Group
NHS South Worcestershire Clinical Commissioning Group
NHS Wyre Forest Clinical Commissioning Group

Contents

This document is an enhanced PDF. Please click on the links throughout to navigate to specific resources.

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.

GPs are also welcome to access Worcestershire Acute Hospitals NHS Trust (WAHT) policy guidelines which are available here.

Introduction

The Worcestershire Gynaecology Transformation Group, 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 Worcestershire NHS services as an emergency.
- To build consistency across 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 shared 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 Worcestershire Gynaecology Transformation group 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
Fertility
Endometriosis / Chronic Pelvic Pain

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:

Information / decisions	Action / Investigation in Primary Care	Routine referral into Secondary Care	Urgent action required

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 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.

This document is the first version and it is therefore anticipated that a second version will be generated in due course with additional referral proformas, plus any amendments following feedback. Please forward any comments to Mr Angus Thomson, Mr Jon Hughes and/or Dr Louise Bramble.

Yours sincerely

GP:
Dr Louise Bramble

Gynaecology Consultants:
Mr Jon Hughes
Mr Angus Thomson

Version Control

Version	Update	Date
0.1	Initial draft	25/01/18
1.0	Release Version	24/10/18

1. Pregnancy: Early Problems

Patient presents with Early Pregnancy Problem
Initial assessment to include:

History:
- Bleeding, pain and other symptoms
- LMP and menstrual cycle history
- Current and previous pregnancies

Examination:
- Clinical observations
- Abdominal +/- bimanual examination of pelvis (if appropriate)

Investigation:
- Urine pregnancy test

Negative Pregnancy Test (no referral)

Positive Pregnancy Test

Unwell/signs of shock immediate transfer to A&E

Referral to Early Pregnancy Assessment Unit (EPAU) if patient is 6 - 16 weeks pregnant with early pregnancy related issues:

i.e.
- Abdominal pain
- Vaginal bleeding
- Previous history of ectopic, molar or recurrent miscarriages

EPAU Clinic Details:

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

Out of Hours Details:

For urgent referrals outside these times contact the on call Gynaecology Registrar via switchboard on **01905 733060**. For stable patients who can wait for a scan / assessment then contact Emergency Gynaecology Assessment Unit (EGAU) (24/7) on **01905 761489**. 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*:
Early Pregnancy Assessment Unit	Not Required	Emergency Gynae SOP	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

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:

- Cyclizine 50mg tds or
- Promethazine 10-20mg tds or
- Prochlorperazine 5-10mg tds (po) or or 3–6 mg BD (buccal)

Referral to Secondary Care if patient unstable, clinically unwell or ketones ≥ (++)

For urgent referrals contact the on call Gynaecology 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.

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

Further review in Primary Care to assess progress

If clinically unwell or ketones ≥(++)

Continue treatment if effective or trial alternative anti-emetics

Patient Information*:	Referral Proforma:	Local Guidance*:	National Guidance*:
RCOG - Hyperemesis Patient Information	Not Required	Hyperemesis Guidance Emergency Assessment	RCOG Hyperemesis Guidelines

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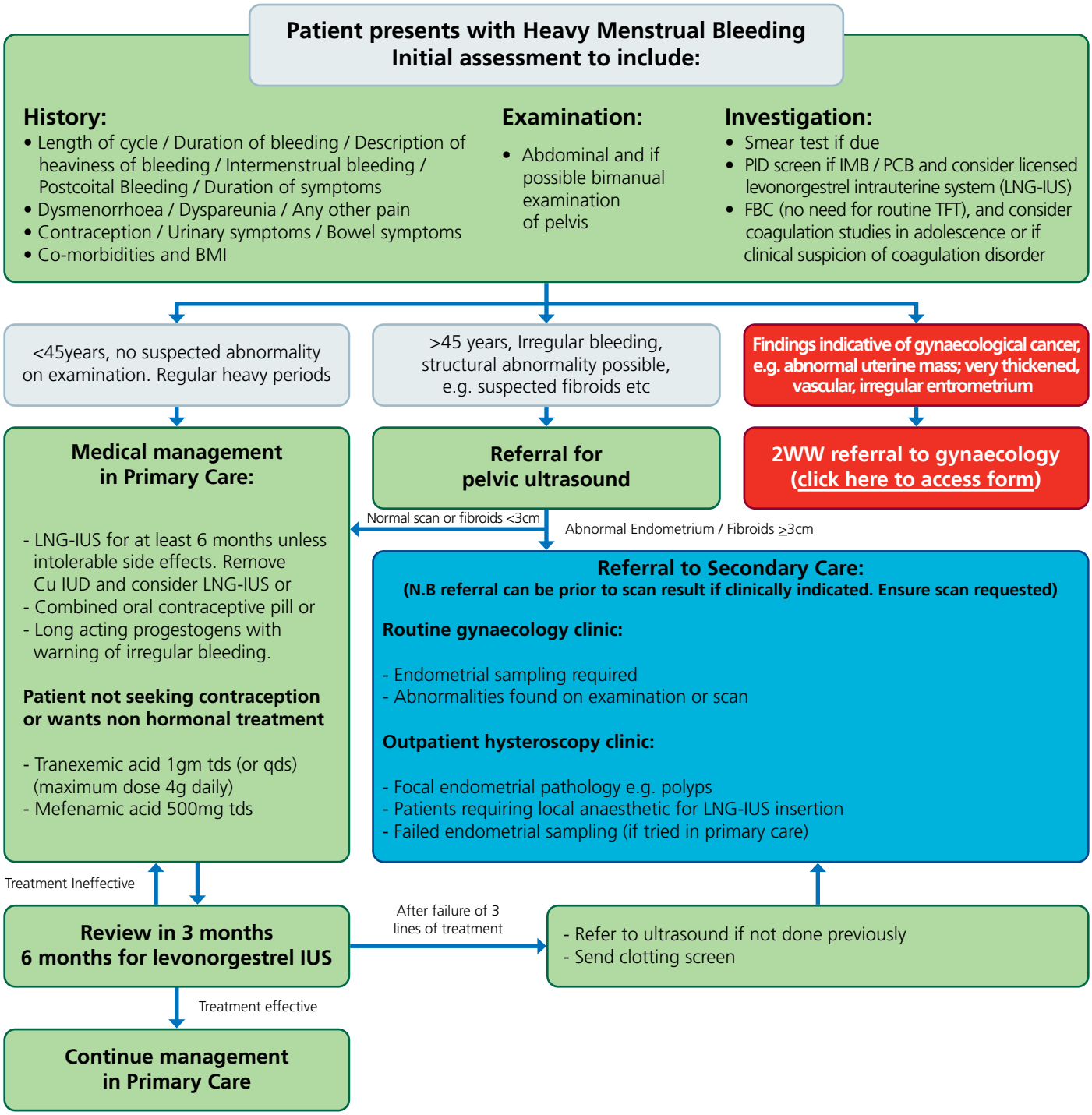
3. Bleeding: Heavy Menstrual



Patient Information*:	Referral Proforma:	Local Guidance*:	National Guidance*:
None Available	Referral for consideration of Hysterectomy for Menorrhagia	Formulary Hormonal Contraception Hysterectomy for Menorrhagia Policy	NICE Guidance

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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 ≥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

Urgent (<4 weeks) referral to Colposcopy if:

- IMB in history of LLETZ or high grade CIN/CGIN (borderline or mild abnormality)

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*:	Referral Proforma:	Local Guidance*:	National Guidance*:
Colposcopy Information Leaflet	2WW and PMB Referral	Under Development	FSRH Guidance Unscheduled Bleeding

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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

Urgent (<4 weeks) referral to Colposcopy if:

- PCB in history of LLETZ or high grade CIN/ CGIN (borderline or mild abnormality)

Urgent / 2WW referral to Colposcopy if:

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

PMB / 2WW referral if:

- Post menopausal

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

Post Menopausal Bleeding:

Post Menopausal Bleeding is defined as bleeding after >12/12 since last period
(**NB** – Unscheduled bleeding on HRT ≥ 3/12 per cyclical or ≥ 6 months for continuous combined, after commencement of treatment is also treated as PMB)

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*:	Referral Proforma:	Local Guidance*:	National Guidance*:
Colposcopy Information Leaflet	2WW and PMB Referral	Under Development	FSRH Guidance Unscheduled Bleeding

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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 if possible 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 ≥ 3/12 per cyclical or ≥ 6 months for continuous combined, after commencement of treatment is also treated as PMB)

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*:	Referral Proforma:	Local Guidance*:	National Guidance*:
PMB Clinic Patient Information	2WW and PMB Referral	2WW and PMB GP Notes	Suspected cancer recognition and referral
Colposcopy Information Leaflet			

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7. Ovarian cysts - General Information

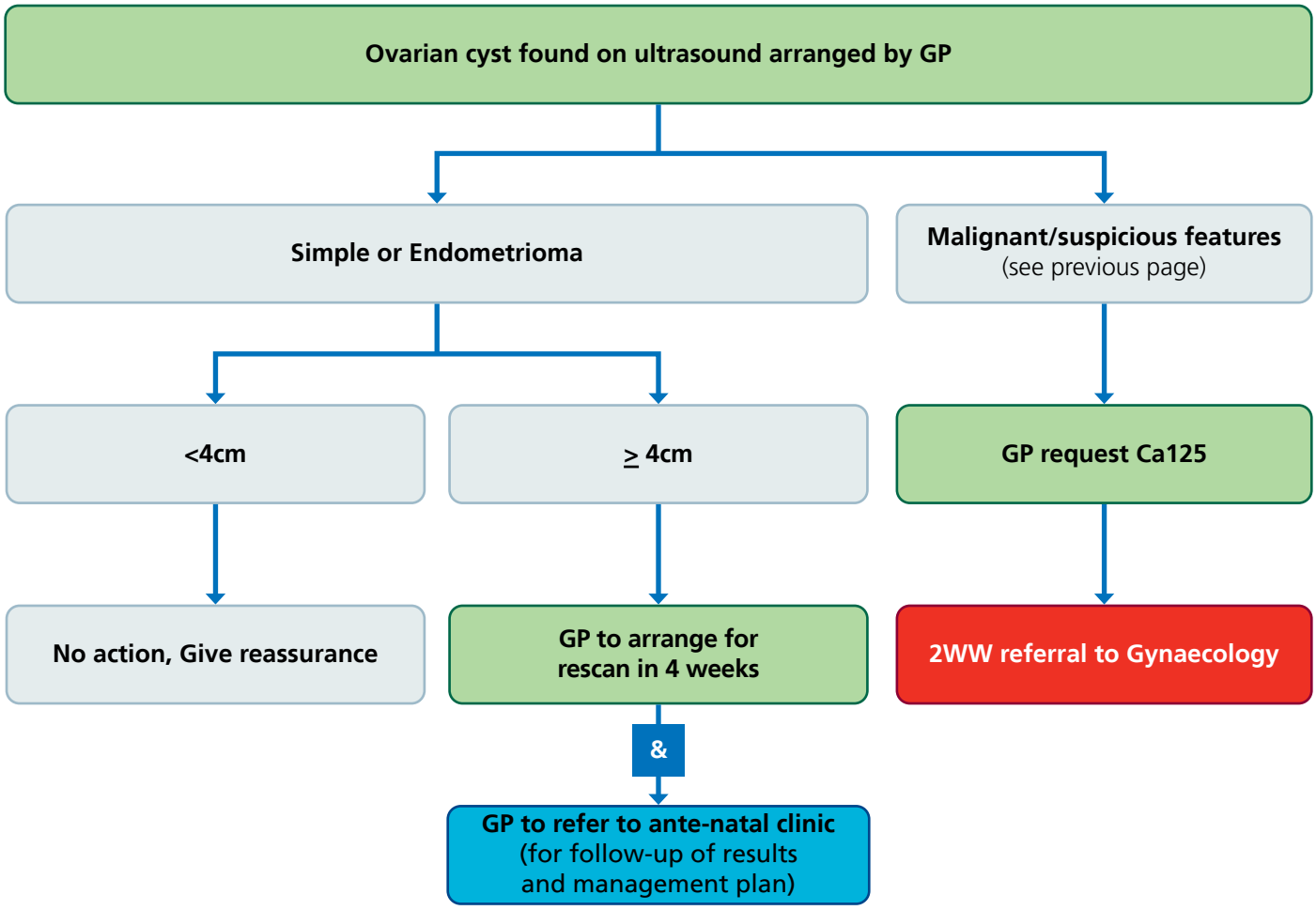
Knowing the options

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: Pregnancy



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	2WW and PMB Referral	2WW and PMB GP Notes	None Available

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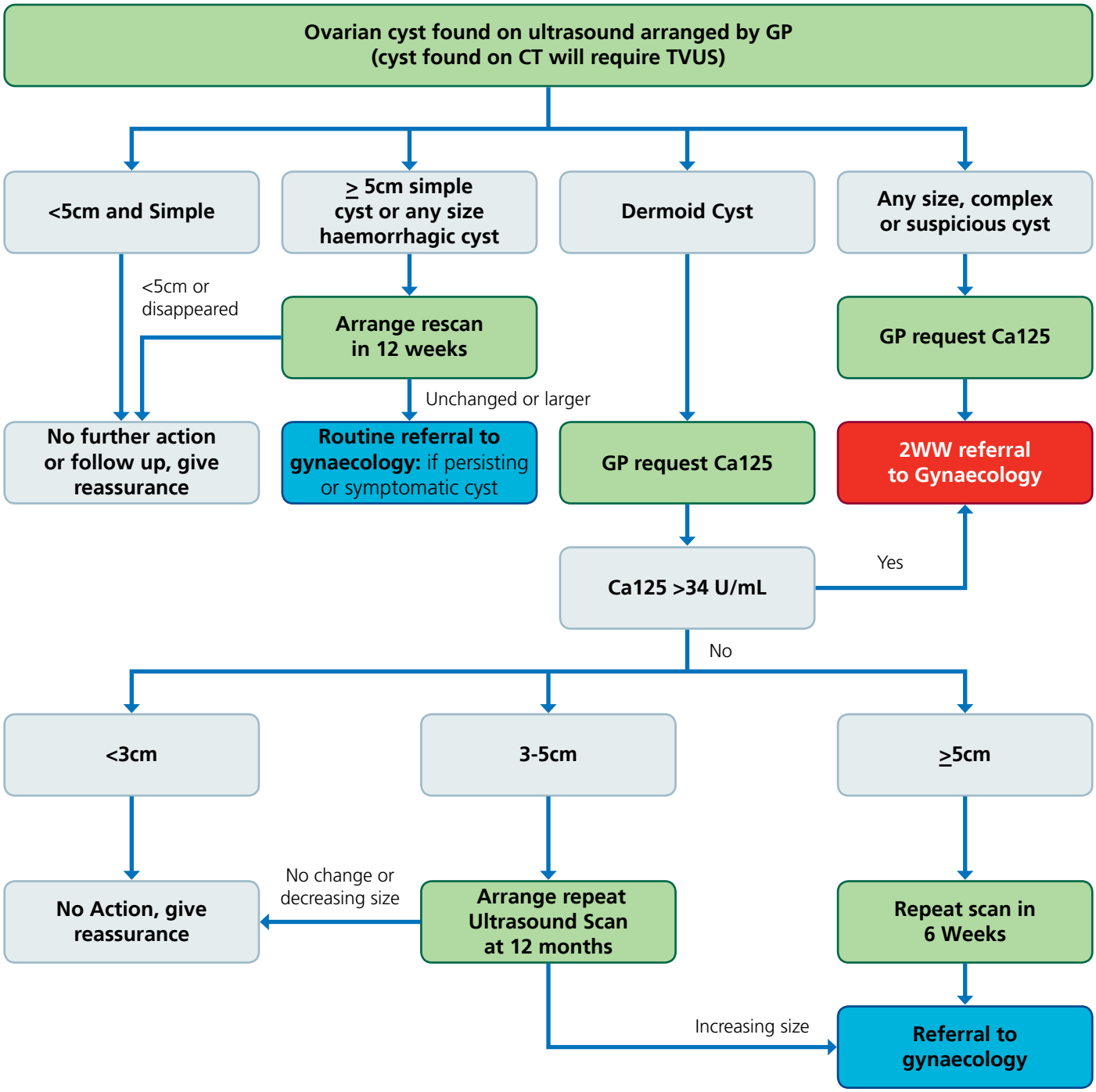
9. Ovarian cysts: Pre-menopausal



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	2WW and PMB Referral	2WW and PMB GP Notes	RCOG Pre-menopausal Cyst Guidelines

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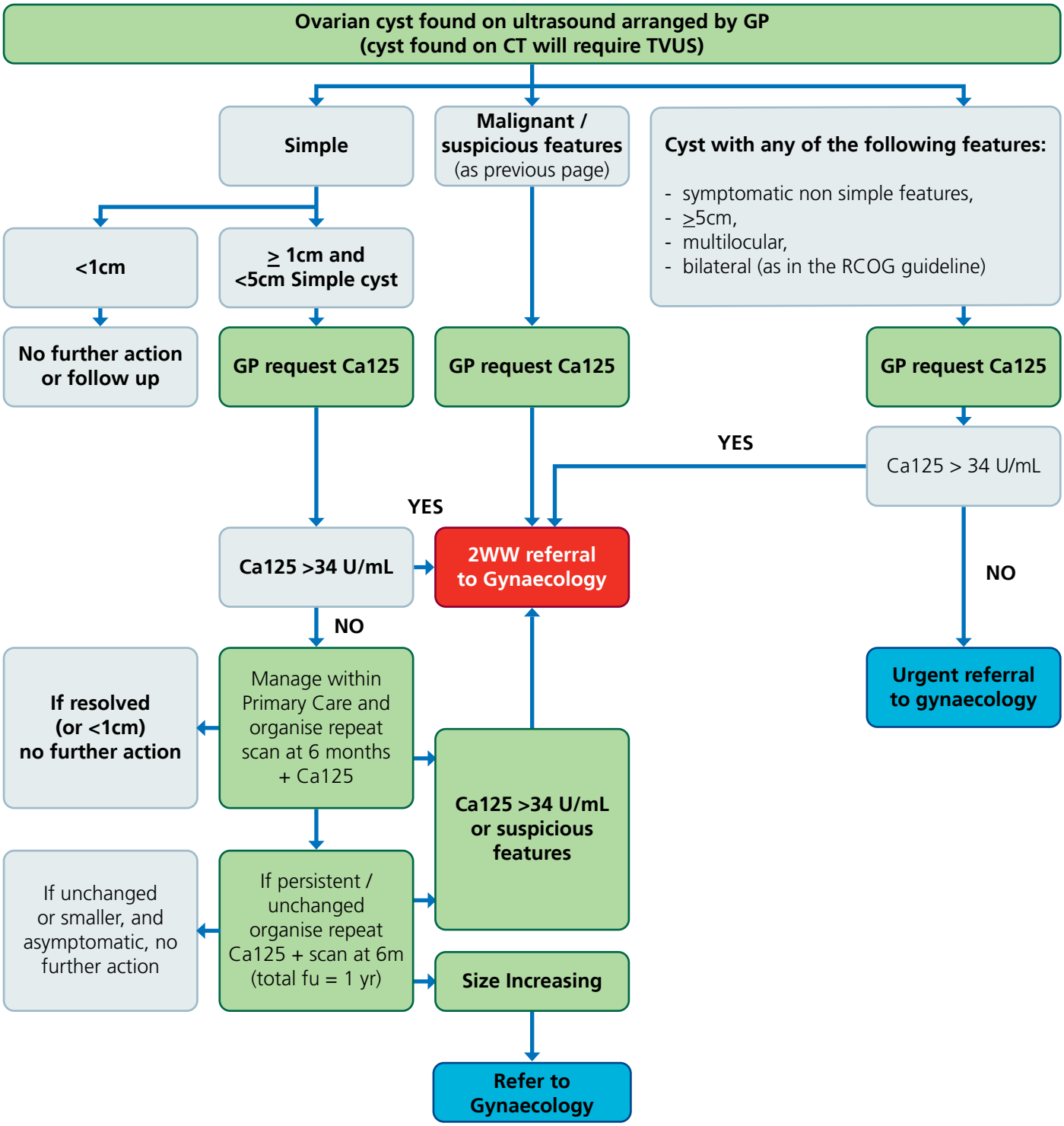
10. Ovarian cysts: Post-menopausal



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

Patient Information*:	Referral Proforma:	Local Guidance*:	National Guidance*:
RCOG Post-Menopause Patient Information	2WW and PMB Referral	2WW and PMB GP Notes	None Available

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

11. Urinary Incontinence

Patient presents with Urinary Incontinence
Initial assessment to include:

History:

- Urinary history (frequency, nocturia, urgency, stress incontinence, urge incontinence, voiding symptoms)
- Prolapse symptoms, Bowel symptoms, Sexual function
- Obstetric / Gynaecological / Surgical history.
- Past medical history, co-morbidities and BMI.
- Any neurological symptoms
- Treatment of underlying constipation

Examination:

- Abdominal, speculum and bimanual examination of pelvis.
- Assessment of prolapse (NB: Prolapse only requires treatment if symptomatic or descend below introitus)

Investigations:

- Urinalysis (+/- MSU if indicated)
- 3 Day Bladder Diary (IN:OUT) – see attachment in GP notes below

Treat UTI if present and manage any underlying constipation
Assess bladder diary

Refer to Secondary Care if:

- Abnormal examination e.g. mass fistula (UG)
- Symptomatic prolapse with incontinence or voiding difficulty (UG)
- Incontinence **and** voiding difficulty
- Recurrent incontinence (UG/Urol)
- Failed previous surgery (UG/Urol)
- Urinary retention (UG/Urol)
- Neurological signs (UG/Urol)
- Bladder pain (UG/Urol)
- Incontinence & recurrent UTI (UG/Urol)
- Haematuria (Urol)

Urge dominant incontinence
(Frequency / Urgency +/- urge incontinence)

- Lifestyle modifications (including weight loss)
- Fluid Management / caffeine
- Bladder retraining
- Pelvic Floor muscle advice
- Prescribe vaginal oestrogens if post menopausal

Stress dominant incontinence

- Pelvic floor exercises / drill x 3 months
- Consider vaginal oestrogens if post menopausal

Review after 3 months
If symptoms persist consider referral to Continence Advisory Service (01905 681602) (+/- repeat diary and bladder scan residual)

Review after 3 months
If symptoms persist consider referral to Gynaecology Physiotherapy for supervised pelvic floor exercise.

Mixed stress and Urge incontinence

Manage according to the dominant problem i.e. stress or urge

If symptoms persist treat overactive bladder and continue bladder training
overactive bladder prescribing - see local guidance link below, consider vaginal oestrogen. Where possible, attempt all treatment options.

If after 6 months no significant improvement - refer to Uro-gynaecology clinic

Patient Information*:

- NHS Patient Information
- Non-Irritant Drinks
- Pelvic Floor Exercises

Referral Proforma:

Under Development

Local Guidance*:

- APC Overactive Bladder Prescribing Guidance
- Bladder Diary

National Guidance*:

- Urinary Incontinence NICE Bites (summary of NICE guidance)

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12. 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
- Manage constipation
- Prescribe vaginal oestrogen if atrophy, recurrent UTI's or pessary used
- Reassurance and watchful waiting if mild symptoms (advise pelvic floor muscle exercises – patient information below)
- If Post Void Residual consider referral to Continence Advisor (01905 681602)
- Consider simple ring pessary

Follow up assessment after 3 months

- Continue management if effective
- Consider referral for physiotherapy or continence advisor if ineffective

Refer to Secondary Care if:

Patient is willing to consider surgery **with**

- **Persistent symptomatic prolapse** including recurrent MSU proven UTI or reduced quality of life despite conservative management **and/or**
- **Prolapse beyond introitus** or worsening prolapse despite conservative measures

NB: Give patient NHS/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.

Refer to General Gynaecologist if:

- Symptomatic prolapse within vagina (Stage I/II) without urinary symptoms, and no previous prolapse surgery

Refer to Urogynaecologist if:

- Prolapse symptoms with urinary symptoms (e.g. incontinence, voiding difficulty)
- Prolapse beyond introitus (Stage III/IV)
- Recurrent UTI's
- Previous prolapse or continence surgery

Patient Information*:	Referral Proforma:	Local Guidance*:	National Guidance*:
Surgery for Prolapse	Referral for Pelvic Organ Prolapse (due end of 2018)	Surgical Management of Pelvic Organ Prolapse (due end of 2018)	None Available
Pelvic Floor Exercises		Bladder Diary	

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13. Fertility

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

Initial advice and management in Primary Care

- Preconception advice leaflet (see attachment below)
- Advise / prescribe folic acid 400mcg per day (5mg if BMI >29 or PMH of diabetes, epilepsy, personal or family history of NT defects, Coeliac disease, sickle cell)
- Smoking cessation advice (both partners)
- Weight loss, where appropriate – exercise and dietary advice (both partners). Emphasise BMI, see BMI Calculator below
- Lifestyle advice regarding alcohol, caffeinated beverages, tight underwear, complementary therapy, prescribed, over-the-counter & recreational drug use, occupation

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 (refer without delay)
   OR
3. Refer without delay 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)

Investigations prior to referral

- Pelvic ultrasound scan
- Female blood tests on day 2-5 of cycle (any time if amenorrhoeic) to include: FSH/LH, prolactin, TSH, testosterone, Rubella
- Semen analysis (see form below)
- Chlamydia screen

Refer to Hospital Fertility Clinic (using proforma below)

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

All patients meeting the fertility 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

NOTE: *These criteria reflect updated policy due to be published by the end of 2018.*

Patient Information*:	Referral Proforma:	Local Guidance*:	National Guidance*:
BMI Target Calculator	GP to Specialist Referral Proforma - Subfertility	Fertility Service Summary	None Available
Semen Analysis Leaflet		Semen Analysis GP Info	
Fertility Information		Semen Analysis Request	
		Assisted Conception Policy	

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14. 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

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

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 Endometriosis clinic if treatment not effective

Click on the above pathway for further information about these conditions.

Patient Information*:
- Non-Irritant Drinks
- RCOG Chronic Pelvic Pain
- Understanding Endometriosis

Referral Proforma:
None Available

Local Guidance*:
None Available

National Guidance*:
- NICE diagnosis and management

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

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.
- Other NHS organisations guidelines and protocols.

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Glossary

Acronym	Meaning
2WW	Two-Week Wait
APC	Area Prescribing Committee
bd	Twice Daily
BMI	Body Mass Index
CIN	Cervical Intra-epithelial Neoplasia
CGIN	Cervical Glandular Intra-epithelial Neoplasia
COCP	Combined Oral Contraceptive Pill
CT	Computed Tomography
Cu IUD	Copper Intrauterine Device
EGAU	Emergency Gynaecology Assessment Unit
EPAU	Emergency Pregnancy Assessment Unit
FBC	Full Blood Count

Glossary (cont)

Acronym	Meaning
FSH	Follicle-stimulating hormone
HRT	Hormone Replacement Therapy
IBS	Irritable Bowel Syndrome
ICE	Pathology System
IMB	Inter-Menstrual Bleeding
IUCD	Intrauterine Contraceptive Device
IUS	Intrauterine System
LA	Local Anaesthetic
LH	Luteinizing Hormone
LLETZ	Large Loop Excision of the Transformation Zone
LMP	Last Menstrual Period
LNG-IUS	Levonorgestrel Intrauterine System
MSU	Mid-Stream Urine
NICE	National Institute For Health And Care Excellence
NSAIDs	Non-Steroidal Anti-Inflammatory Drugs
NT	Neural Tube
PCB	Post Coital Bleeding
PID	Pelvic Inflammatory Disease
po	Oral
POP	Progesterone Only Pill
PMB	Post-Menopausal Bleeding
RCOG	Royal College of Obstetricians and Gynaecologists
Rx	Prescription
tds	Three times daily
TFT	Thyroid Function Test
TSH	Thyroid Stimulating Hormone
TVUS	Transvaginal ultrasound scan
U&E	Urea and Electrolytes
UG	Urogynaecology
USS	Ultrasound Scan
UTI	Urinary Tract Infection
Urol	Urology