Metro South Health

Quality healthcare every day

Metro South Health and Hospital Service

GP Gynaecology Education Day

2nd March 2024

ICARE² values

INTEGRITY COMPASSION ACCOUNTABILITY RESPECT ENGAGEMENT EXCELLENCE

Queensland Government

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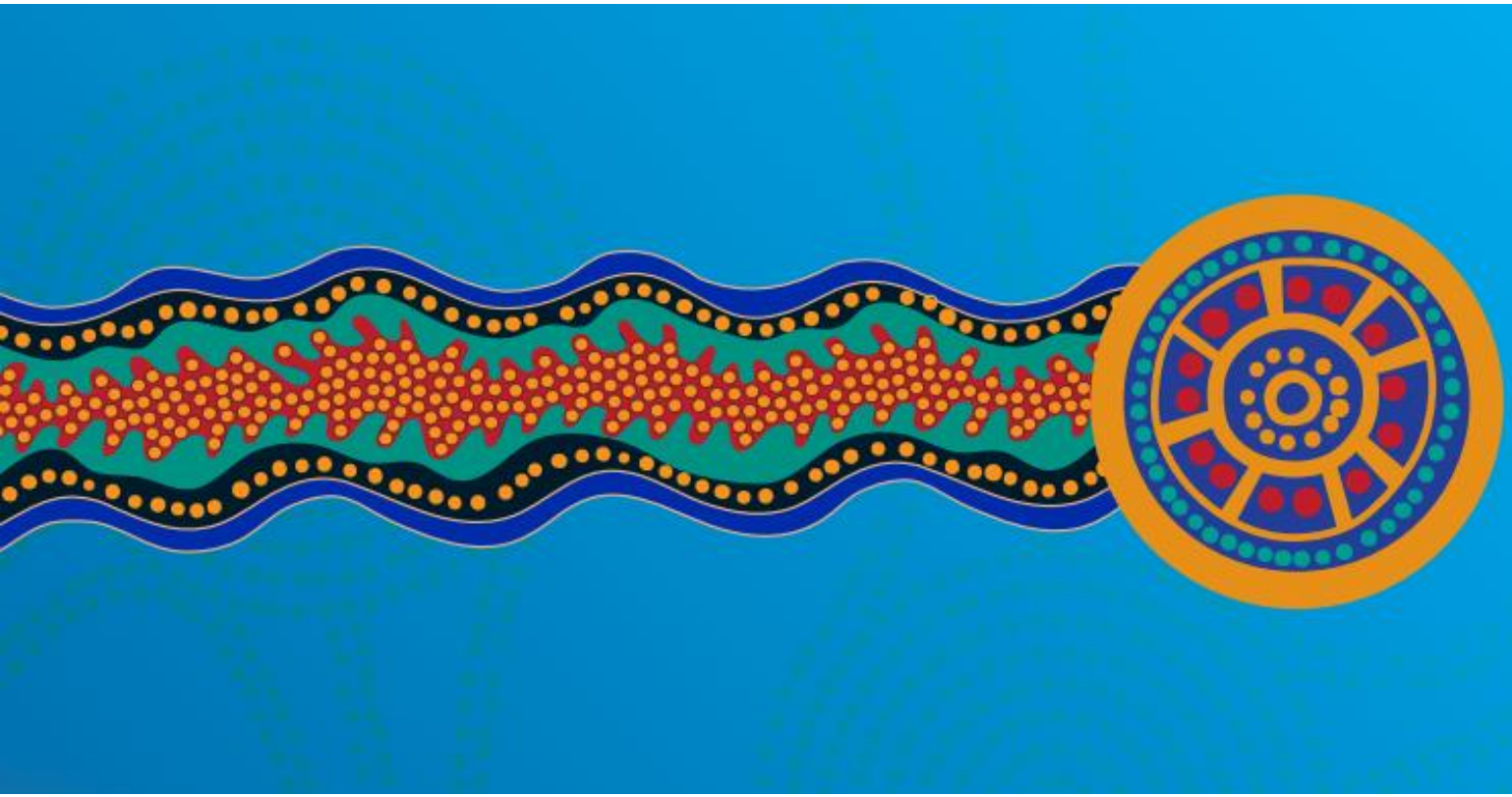

Metro South Health acknowledges the Yugambeh, Quandamooka, Jaggera, Ugarapul and Turrbal, the traditional Custodians of the land on which we meet today, recognising their shared country, their continuing connection to the lands, the waters, and communities.

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

ICARE² values

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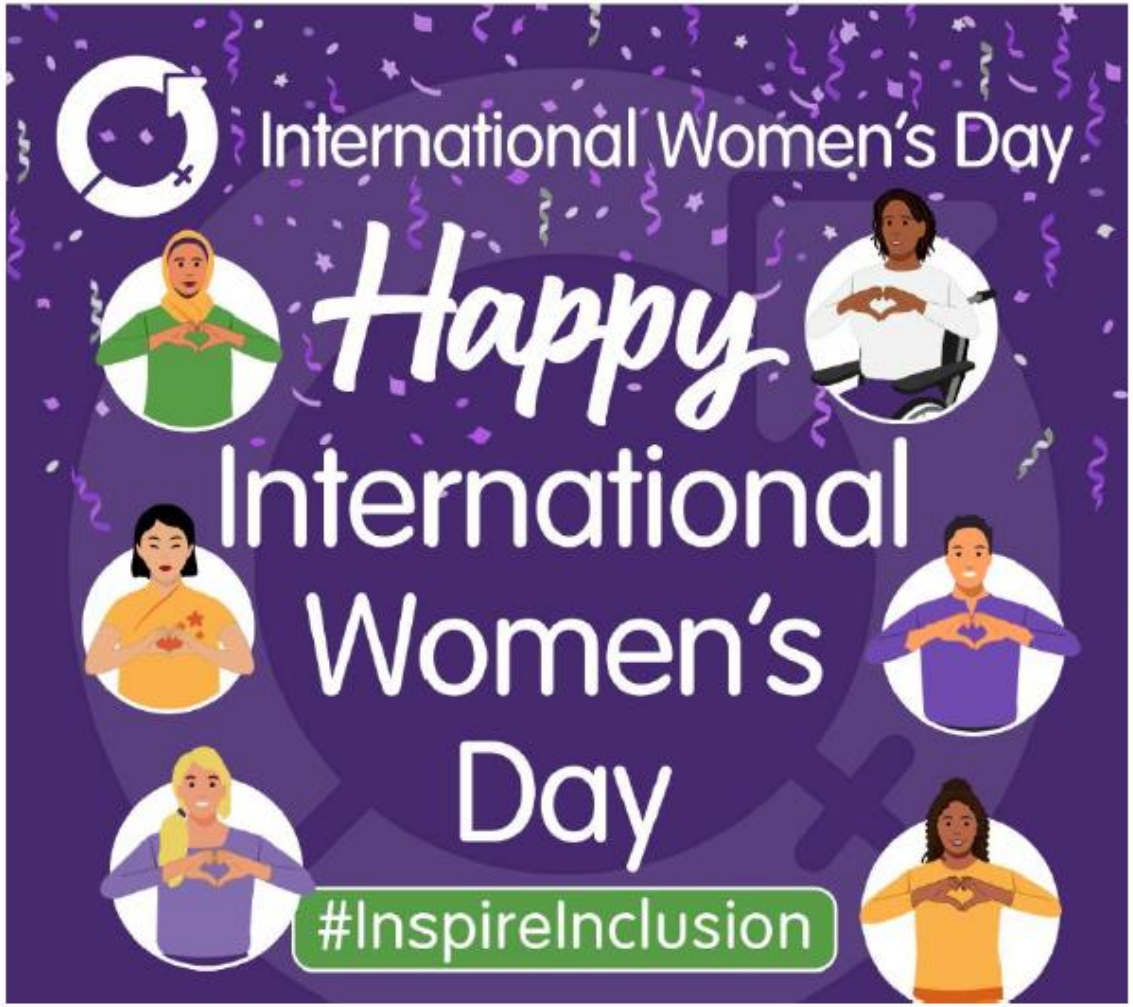
In our education today, we recognise the importance of recognising those people who do not identify as women when discussing our care for gynaecological and reproductive health issues. We respectfully acknowledge that some people may not identify as 'female' or as having a lived experience of 'womanhood'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



Imagine a gender equal world. A world free of bias, stereotypes, and discrimination. A world that's diverse, equitable, and inclusive. A world where difference is valued and celebrated. Together we can forge women's equality.

Collectively we can all #InspireInclusion.

Celebrate women's achievement. Raise awareness about discrimination. Take action to drive gender parity.

#CountHerIn

#IWD2024

Theme for International Women's Day 2024 is
Count Her In: Invest in Women. Accelerate Progress, based on the priority theme for the United Nations 68th Commission on the Status of Women, **Count Her In** will examine the pathways to greater economic inclusion for women and girls everywhere.

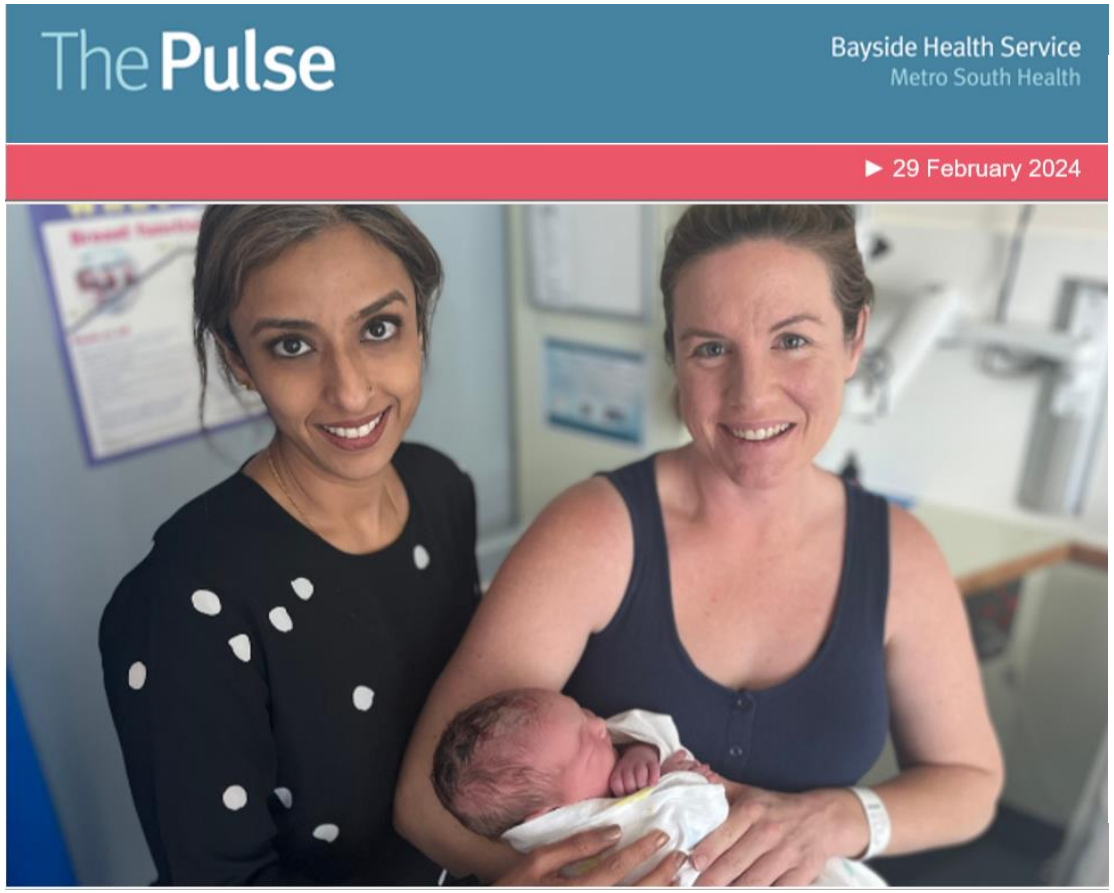
Introducing today's team …..

- Facilitator: Dr Kim Nolan , GP - GPLO Maternity
- Lisa Miller, GPLO Midwife Manager

From Logan, Beaudesert, QE II (and Redland Hospital) Teams

- Dr Hasthika Ellepola
- Dr Katie Christensen
- Dr Sanja Savic
- Dr Dulanthi Tudawe
- Melanie Walkenhorst
- Nellie Phillips
- Dr Herjot Gill
- Dr Lua Saylany
- Dr Allison Garvey
- Dr Bruce (Chuan) Wang

+ Guest Presenter: Dr Andy Perry (Clontarf GP/Marie Stopes International)



Motivated by the magic of new life - welcome Dr Gill!

Bayside Health Service has welcomed its new Director of Obstetrics and Gynaecology Dr Premjit Gill who is motivated by the magic of welcoming new life into the world.

"My first interest in women's health started in medical school, " she said. "When I was a junior doctor - I enjoyed working in different specialities.
"However, I was always drawn back into obstetrics and gynaecology no matter what I did. I had phenomenal people who mentored me and cultivated my interest."

Dr Gill previously served as a Staff Specialist in a large tertiary centre in Melbourne and had the opportunity to meet the Bayside team last year.

Welcoming Dr Prem Gill to the MSHHS O & G Team – new Director at Bayside HHS

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 self-reporting of CPD points - Reviewing Performance Gynae GP Education Day - Sat 2nd March 2024

Red Case – Task 1	**Green Case – Task 1**	**Pink Case – Task 1**
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
8:30 am	Welcome, Housekeeping, learning objectives.	Dr Kim Nolan	GP Facilitator
8:40 am – 9.00 am	Task 1 Breakout groups – Case Discussion	Breakout	Facilitated groups
9.00 am	Case Discussion – ToP	Group Spokesperson Dr Andy Perry Nellie Phillips	Facilitated groups Power Point Presentation & Forum Discussion
9:40 am	Case Discussion – Abnormal Cervical Screening Test Follow Up	Group Spokesperson Dr Kim Nolan Dr Dulanthi Tudawe	Facilitated groups Power Point Presentation & Forum Discussion
10.20 am	Morning Tea	ALL	ALL

Session 2

Time	Session name	Presenter	Delivery
11.00 am	Case Discussion – Heavy Menstrual Bleeding	Group Spokesperson Dr Kim Nolan Dr Hasthika Ellepola	Facilitated groups Power Point Presentation & Forum Discussion
11:40 am	Case Discussion – Pelvic Floor Prolapse	Group Spokesperson Dr Hasthika Ellepola	Facilitated groups Power Point Presentation & Forum Discussion
12:10 am	Case Discussion – Incontinence	Group Spokesperson Dr Kim Nolan Dr Sanja Savic	Facilitated groups Power Point Presentation & Forum Discussion
12:40 noon	Physiotherapy Management of Prolapse, Urinary and Faecal incontinence; Physiotherapy Pelvic Health Service in MSHHS	Melanie Walkenhorst	Practical Demonstration ALL
1:00 pm	LUNCH	ALL	ALL

Session 3

Time	Session name	Presenter	Delivery
1:45 pm	Hands –On Practical Demonstrations - Speculum Use - Implanon Insertions - IUD Insertion - Pelvic Floor Muscle Anatomy - Pipelle Biopsy Demo - Q & A with Gynaecologist	Breakout Group Rotations	Facilitated groups Power Point Presentation & Forum Discussion
2:45 pm	Case Discussion – Pelvic Pain/Endometriosis	Group Spokesperson Dr Katie Christensen	Facilitated groups Power Point Presentation & Forum Discussion
3:45 pm	Wrap Up CPD Discussion – Self Logging	Dr Kim Nolan ALL	ALL

Learning Objectives

- Improve knowledge of common gynaecological conditions and recommended 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.

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Termination of Pregnancy

Dr Andy Perry
GP and Marie Stopes International Medical Officer

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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.

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.

Termination of pregnancy

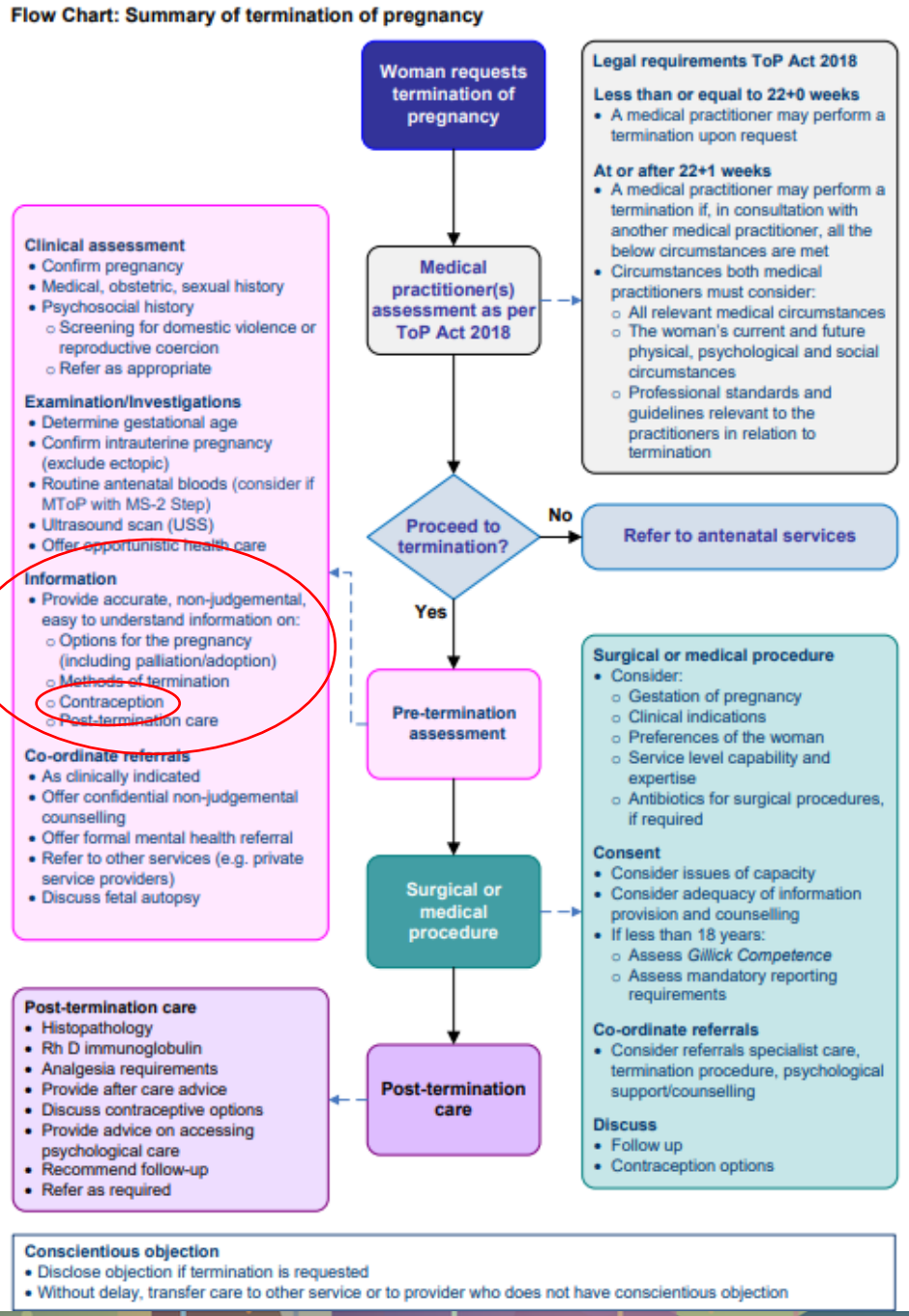
Termination of Pregnancy Act 2018

- 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

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.

Clinicians have advised that education and governance is needed for clinical staff using mobile / bedside USS to confirm intrauterine viable pregnancy for early gestation.

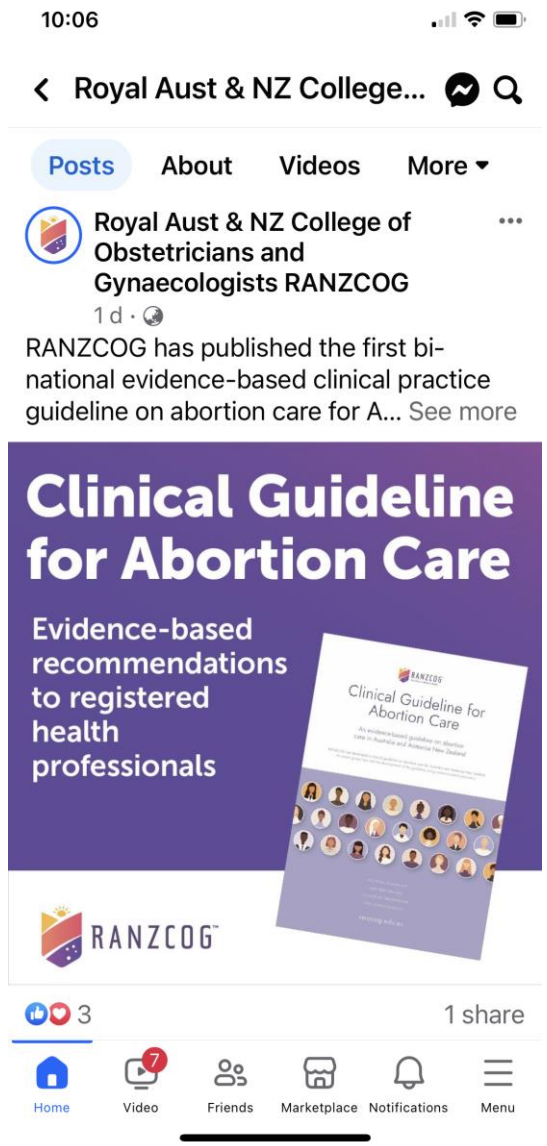


Guideline: Termination of pregnancy (health.qld.gov.au)

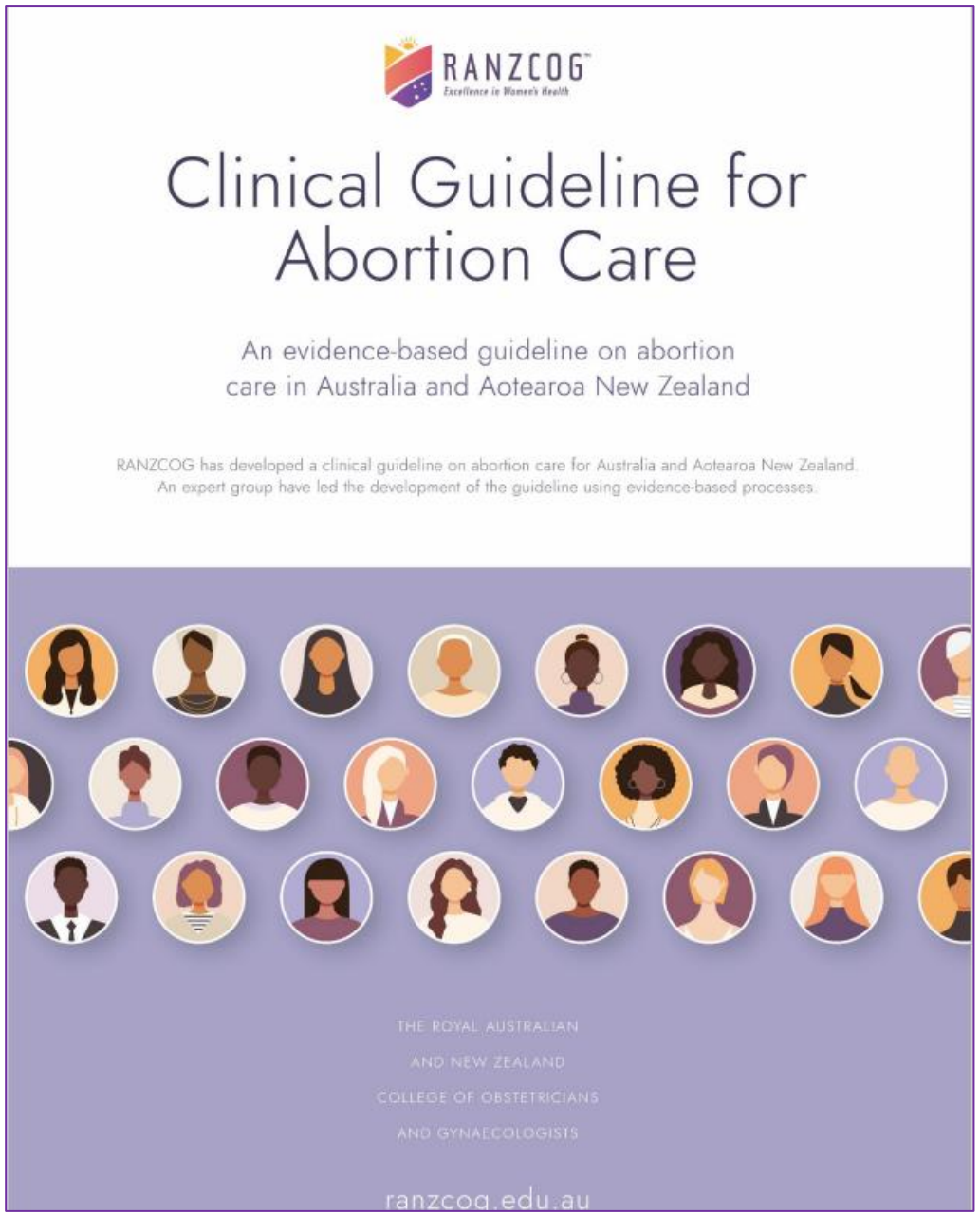
- Australia has a relatively high rate of unintended pregnancy (19.7 per 1000 women aged 15–44 years).
- Australia ranks amongst the highest countries for termination of pregnancy in the developed world with 1 in 4 women undergoing a termination procedure.

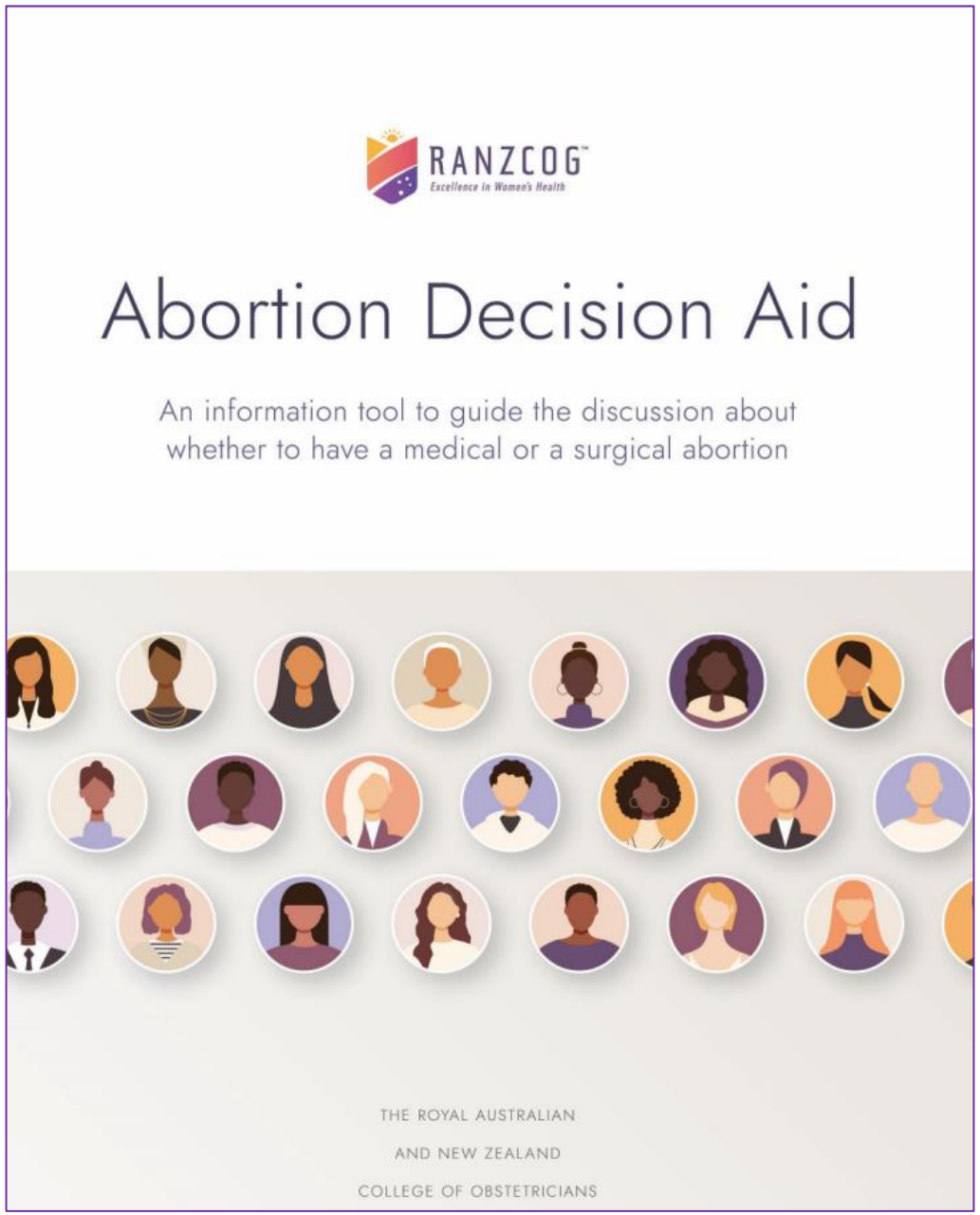
https://www.health.qld.gov.au/__data/assets/pdf_file/0029/735293/g-top.pdf

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]

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:

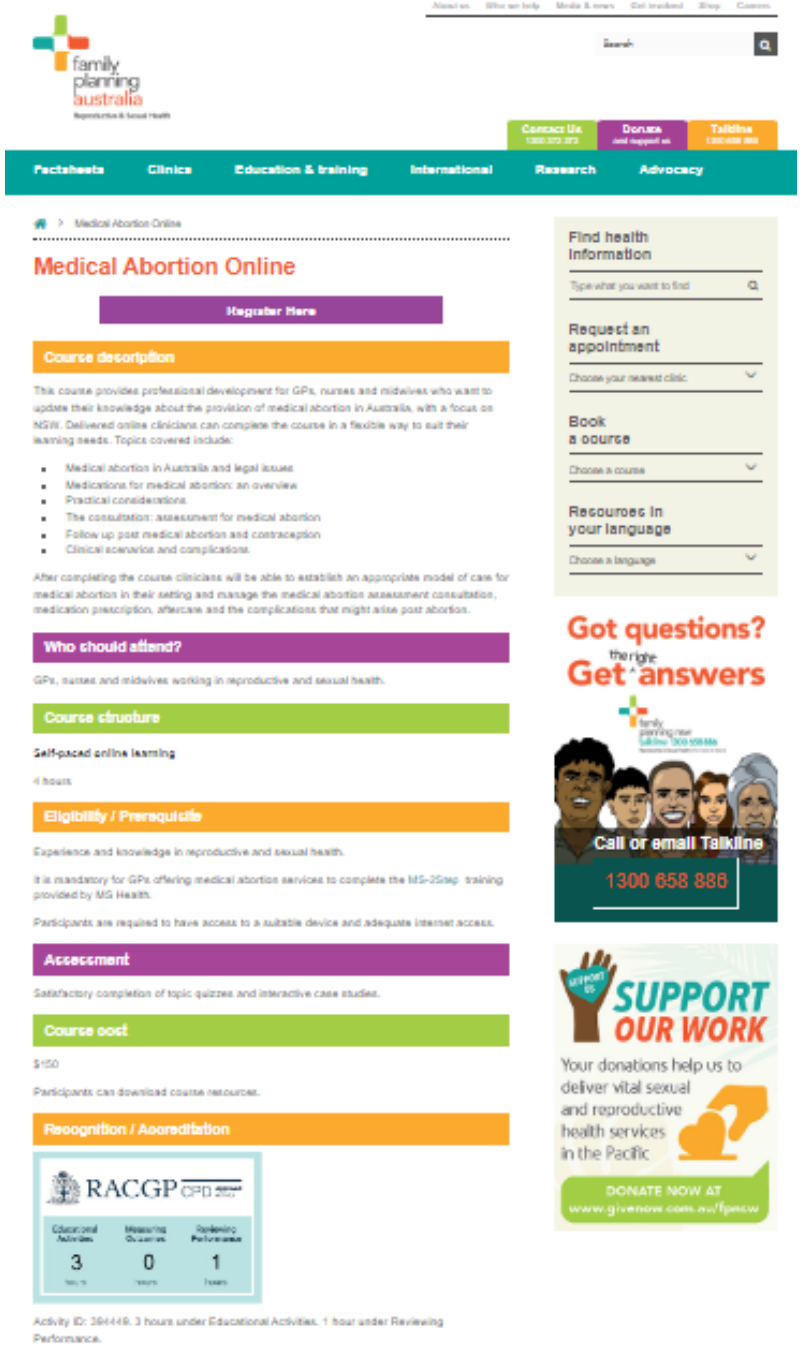
- Offering paracetamol (1000 mg 4 to 6 hourly as required with a maximum 4000 mg per 24 hours) in addition to ibuprofen with antiemetic 30 minutes prior to administration of misoprostol
- Considering selective use of opiate analgesia

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 (in draft)
- 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/medical-abortion-online

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



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 coming soon!

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

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)
- Assessment and screening for domestic violence & reproductive coercion is important. Each woman referred to the service 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)

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[68] 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/

Queensland Health

Queensland Clinical Guidelines

*short*GUIDE

Rh D negative women and pregnancy

Sensitising events

Aspect	Consideration

First 12+6 weeks of pregnancy[6]	• Miscarriage[26]
	  ○ Excludes threatened miscarriage—consider confirming gestational age by ultrasound scan
	• Termination of pregnancy[26]
	  ○ Surgical at any gestation
	  ○ Medical after 10+0 weeks gestation
	• Ectopic pregnancy[26]
	• Molar pregnancy[26]
	• Chorionic villus sampling[26]

https://www.health.qld.gov.au/__data/assets/pdf_file/0016/1219003/g-rhd-negative.pdf

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)

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

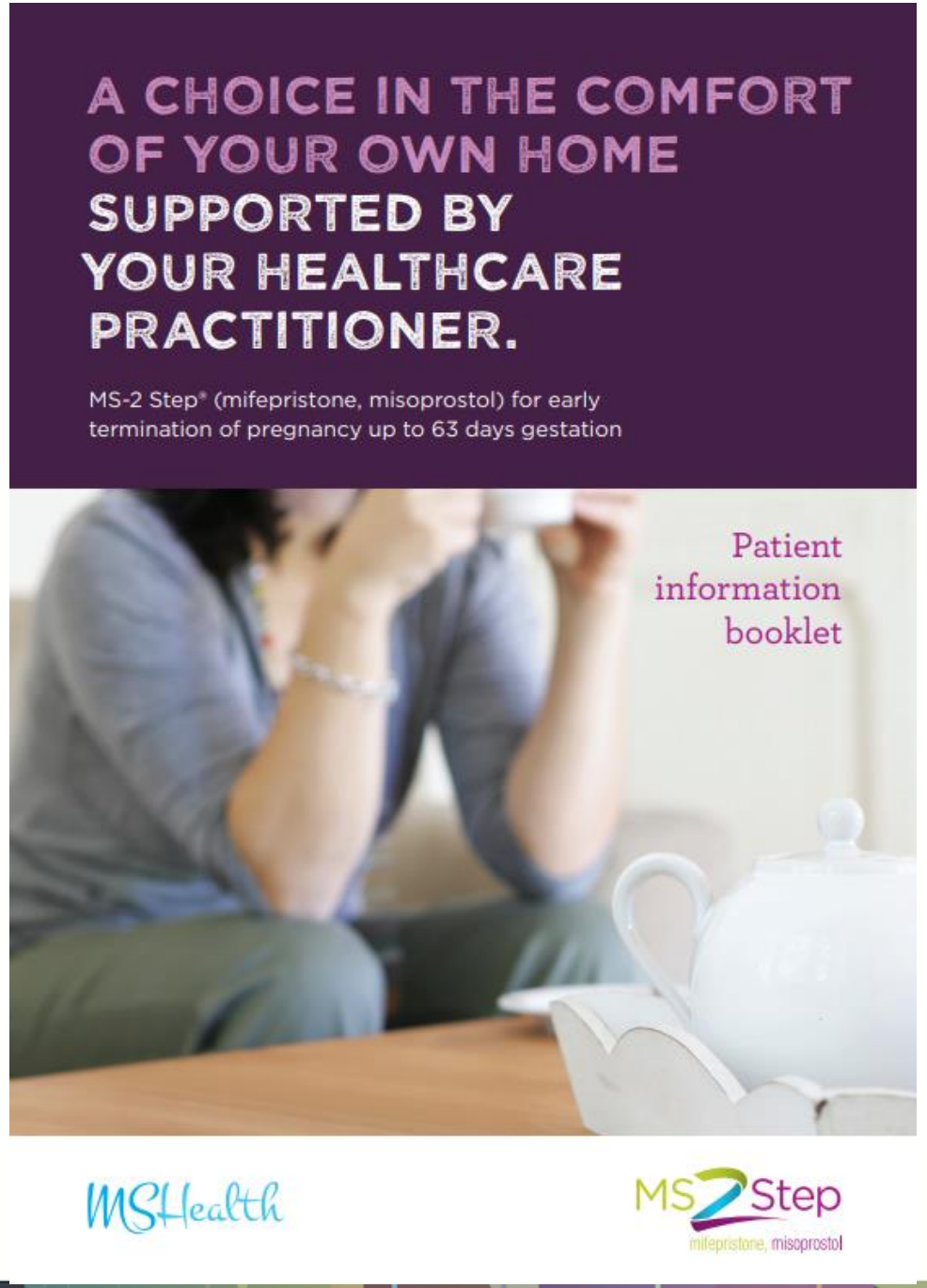
- Admission to hospital for D&C / Hemorrhage

- Reporting SAE’s 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 Dr Kim Nolan for Lynnelle Phillips, Nurse Navigator
LBH Early Pregnancy Assessment Unit & MSHHS Termination of Pregnancy 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)
- **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

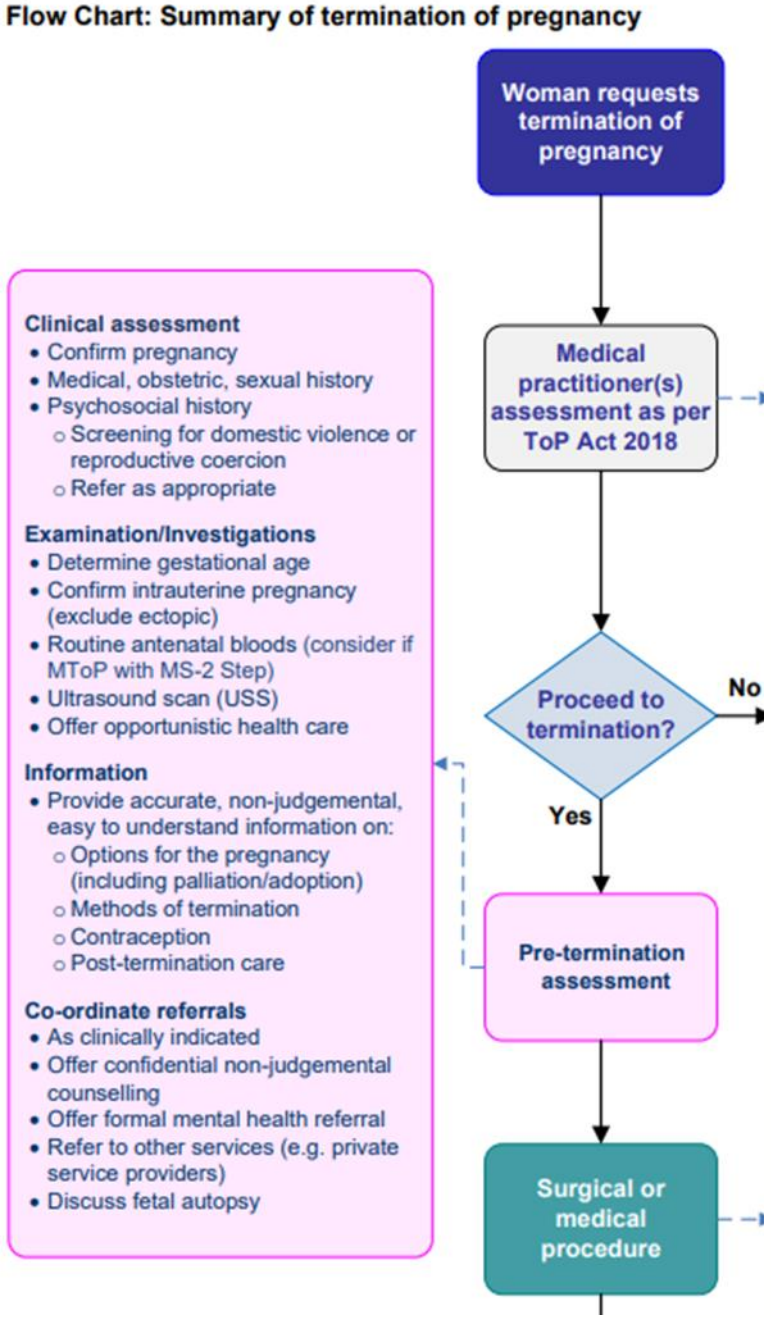
  - **Contact** Phone: 0459 462 478 (Mon – Fri 9am to 4pm)

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!

- 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 * & Blood group and hold**

"Refer Your Patient" - Gynaecology - Termination of Pregnancy

* Ensure sensitive treatment noted on the USS request - If appropriate, ask women about their preference to see/hear USS images

Cervical Shock
Dysmenorrhoea
Dyspareunia (Deep or Superficial)
Low-risk Endometrial Cancer – Follow-up
Endometriosis
Female Genital Mutilation (FGM)
Menopause
Ovarian Cyst
3rd and 4th Degree Perineal Tear Follow-up
Persistent Pelvic Pain
Polycystic Ovarian Syndrome (PCOS)
Premenstrual Syndrome (PMS)
Prolapse
Vaginal Pessaries
Subfertility
Termination of Pregnancy (TOP)
Follow-up (TOP)
Termination of Pregnancy (TOP) Services
Termination for Fetal Anomalies or Genetic Disorders
Urinary Incontinence in Women
Vulvodynia
Gynaecology Requests

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

Management

Before prescribing

1. Manage any acute or specific circumstances:
   - Suspected ectopic pregnancy – arrange emergency assessment
   - Suspected child abuse
   - Suspected sexual abuse of a child or young person
   - Domestic and family violence
   - Recent sexual assault
   - Perinatal mental health concerns
   - Suspected coercion
   - Pregnancy > 63 days' gestation confirmed on ultrasound – request surgical abortion or inpatient MTOP
2. Request termination of pregnancy from the public hospital for multidisciplinary assessment and support if the patient is:
   - aged < 14 years (if required by local guidelines).
   - aged < 18 years and not Gillick competent.
   - an adult lacking capacity.
3. If ultrasound shows a pregnancy of unknown location with no signs or symptoms of ectopic pregnancy, a quantitative beta hCG <the discriminatory zone and the patient is < 6 weeks' gestation by dates, either:
   - consider suitability for very early medical abortion (VEMA) and request termination of pregnancy from an experienced provider.
   - delay termination of pregnancy until repeat ultrasound confirms an intrauterine pregnancy.
4. Provide verbal and written information about MTOP.
5. If intrauterine device (IUD) is in situ, remove before the procedure.
6. If present, manage patient precautions for MTOP as appropriate.

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

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

Logan – New Services across Logan are coming!
YFS (limited at moment)
376 Kingston Road
Slacks Creek QLD 4127
Australia

Phone: 07 3281 4088
Fax: 07 3282 7088

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

6. Arrange investigations ^ if not already done.

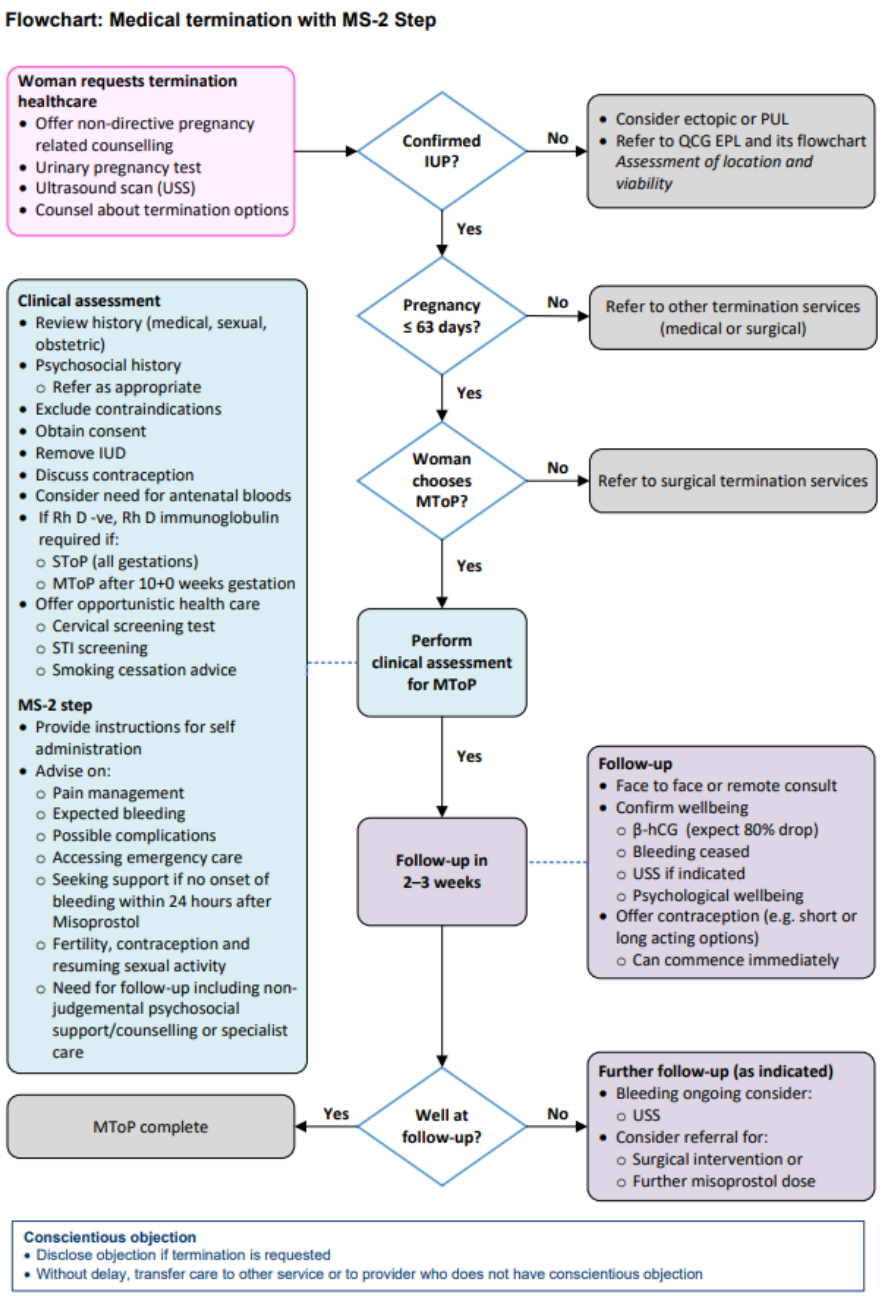
> **Investigations**
>
> - Ultrasound to confirm location of pregnancy and gestational age v.
> - Quantitative beta hCG ≤ 24 hours before taking mifepristone (step 1) if using quantitative beta hCG to ensure completion of MTOP at follow-up v.
> - Chlamydia and gonorrhoea PCR (low vaginal self-swab is 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.
> - Cervical screening, only 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).

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 done
- 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

Early Medical Abortion Education

Changes to prescribing rules & dispensing of MS-2 Step, are significant steps in increasing access to early medical abortion.

In promoting excellence in compassionate abortion care education, the following resources may assist new and emerging clinicians:

- Termination of pregnancy – a good practice guide for Tasmanian care providers (womenshealthtas.org.au)
- Early medical abortion - Women's Health Victoria (whvtraining.com.au) – free online training module
- AusCAPPS Network (The Australian Contraception and Abortion Primary Care Practitioner Support) Network

TERMINATION OF PREGNANCY: SUMMARY OF GOOD PRACTICE INDICATORS

Features of good practice	Indicators of good practice
Privacy and confidentiality	☐ My service safeguards privacy and confidentiality through a privacy management plan that includes protocols for patient records management, document management, referral processes, email and phone communication.
	☐ Clinical and non-clinical staff at my service receive privacy and confidentiality training.
Accessibility	☐ My service redirects patients whose specific needs we cannot meet to alternative referral pathways, including during service closures.
	☐ Staff at my service are aware of financial support schemes for termination care in Tasmania and actively promote these to patients.
	☐ My service provides patients with contact details for out-of-hours health advice and support.
Non-judgemental practice	☐ Practitioners at my service offer non-directive health care to all pregnant people.
	☐ Patient experience is regularly evaluated at my service with a view to continuous improvement.
Trauma informed practice	☐ Clinical and non-clinical staff at my service receive training in trauma informed practice.
	☐ Patients at my service are offered information about pre- and post-termination psychological support.
Clarity of information	☐ My service provides *clear, current, consistent and inclusive* information on where and how to access a termination in Tasmania.
	☐ My service provides patients with accurate, impartial and complete information about all aspects of the termination process.
Treatment options	☐ Where possible within clinical guidelines, patients at my service are offered a choice between a medical or surgical termination.
	☐ Patients at my service are informed about public and private treatment options and financial support schemes.
Specialised knowledge	☐ Practitioners at my service connect with other termination care providers to share specialised knowledge and resources.
	☐ Practitioners at my service deliver an evidence-based model of termination care.
Inclusion	☐ Clinical and non-clinical staff at my service receive diversity and inclusion training.
	☐ Practitioners at my service provide equitable care to all patients regardless of age, gender, sexuality, disability, education, social status, regionality, culture, religion or language.
Communication	☐ Practitioners at my service communicate clearly, sensitively and impartially with patients.
	☐ Practitioners at my service communicate clearly and discretely with other service providers.
Continuity of care	☐ My service has considered ways to streamline the delivery of termination care, including reducing the number of appointments across multiple service settings.
	☐ Practitioners at my service have connected with relevant health services in the region to establish a reliable termination care pathway.
Aftercare	☐ Practitioners at my service routinely book a post-termination appointment to assess patients' physical and emotional wellbeing.
	☐ Patients at my service are given contact details for post-termination medical support, including out of hours.

AusCAPPS | Medcast

ABOUT THIS NETWORK

Our project and mission

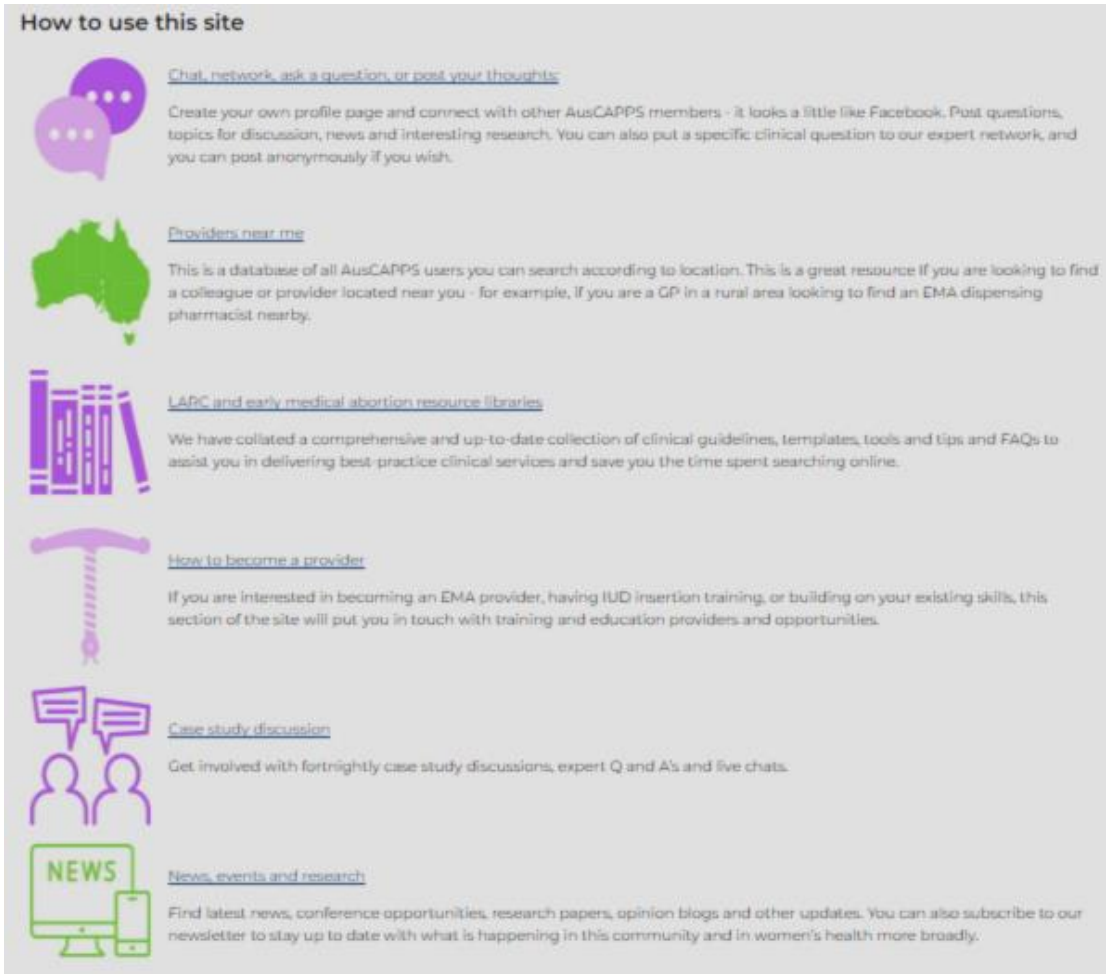
AusCAPPS Network (The Australian Contraception and Abortion Primary Care Practitioner Support Network) is an NHMRC-funded project designed to connect the primary care workforce and increase women's access to contraception and abortion.

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.



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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.

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

- Up to 9 weeks gestation
- No referral required
- Ultrasound through local imaging provider
- Phone/video clinical consultations
- Medications delivered to your home
- Support person recommended for Day 2
- Less than 4% incomplete abortion risk
- Medium to heavy bleeding
- Variable pain
- Self-managed follow up

Medical abortion in clinic

- Up to 9 weeks gestation
- No referral required (except WA)
- Ultrasound in clinic
- In person clinical consultations and support
- Medications provided in clinic
- Support person recommended for Day 2
- Less than 4% incomplete abortion risk
- Medium to heavy bleeding
- Variable pain
- Self-managed follow up

Learn more about in-clinic medical abortion

Surgical abortion

- Up to 20 weeks gestation in some states
- No referral required (except WA)
- Ultrasound in clinic
- In person clinical consultations and support
- In a licensed day surgery
- Sedation or local anaesthetic
- Support person required for pick-up
- Less than 2% incomplete abortion risk
- Light bleeding
- Follow-up not usually required

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

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

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
- 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

Metro South Health

Quality healthcare every day

Follow Up Abnormal Cervical Screening Test

Dr Dulanthi Tudawe
Staff Specialist Obstetrics and Gynaecology
Logan Hospital

ICARE² values

INTEGRITY COMPASSION ACCOUNTABILITY RESPECT ENGAGEMENT EXCELLENCE

Queensland Government

Green Group – Task 1

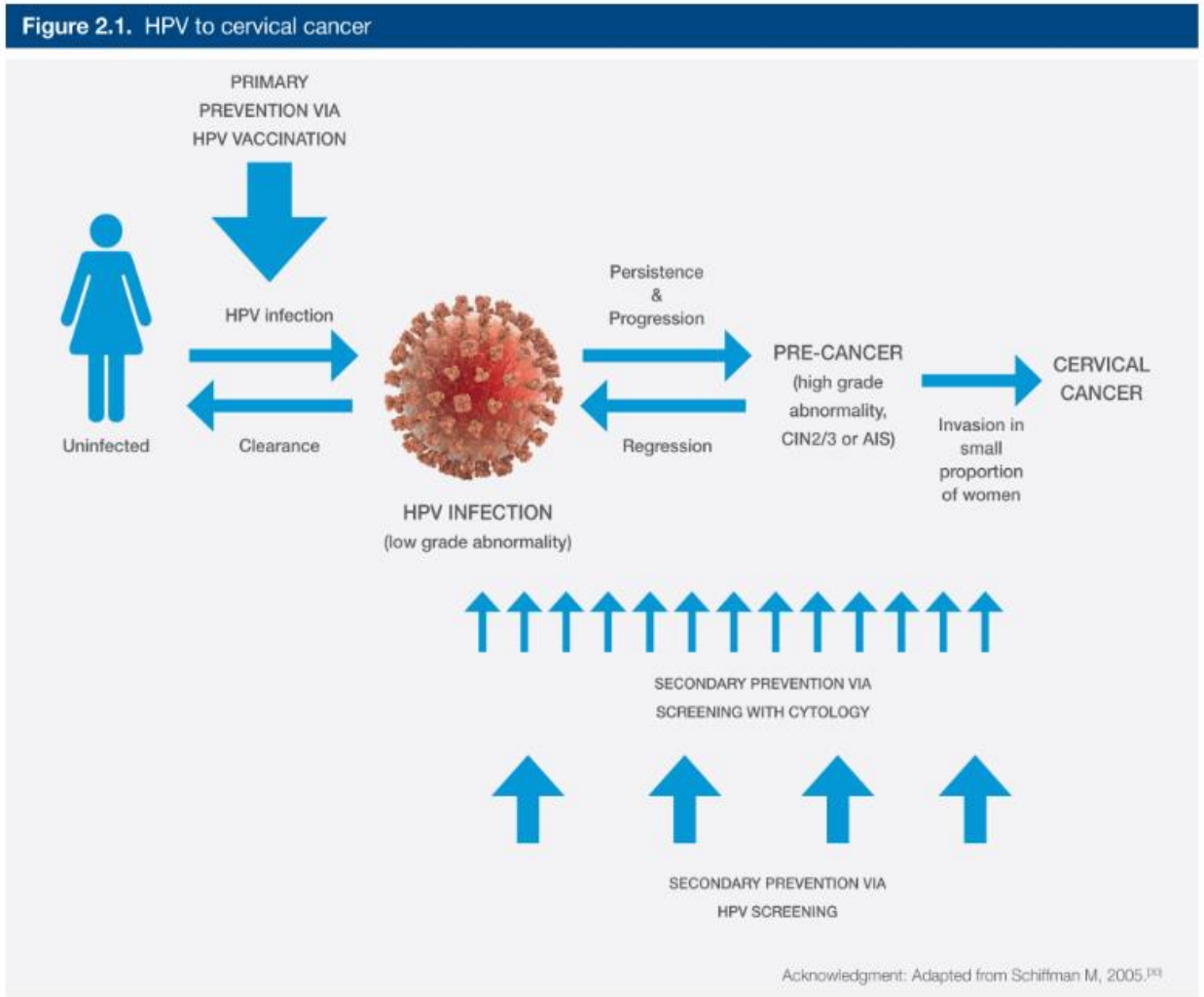
- Zuri is aged 32 years, and she and her current partner have been trying to fall pregnant for the last 3 years.
- PHX genital HSV but no recurrences for 18 months.
- Her history also includes CIN 3 when in her mid 20's – she had surgery at that time and attended for follow up for a few years, but then lapsed in going back to the hospital in Sydney.
- Zuri moved to Australia from Kenya at age 17 years.

She has a 15 min appointment - Outline your approach

Human Papilloma Virus

- Over 100 different types of human Papilloma (HPV) have been identified and there are more 40 anogenital HPV types, 15 of which classified as ‘high risk’ or oncogenic.
- Persistent infection with oncogenic HPV types is generally subclinical but increases risk of a range of anogenital tumours including cancers of cervix, anus, penis, vulva and vagina.
- HPV infection is also associated with squamous cell carcinomas of head and neck, particularly oropharyngeal cancers
- HPV infection is necessary, but not sufficient for development of cancer of the cervix. 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

Figure 2.1. HPV to cervical cancer



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

CLINICAL GUIDELINES SITEMAP

Cancer Council Australia

- 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, while HPV 18 accounts for a further 10–15% of cervical cancers.
- 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

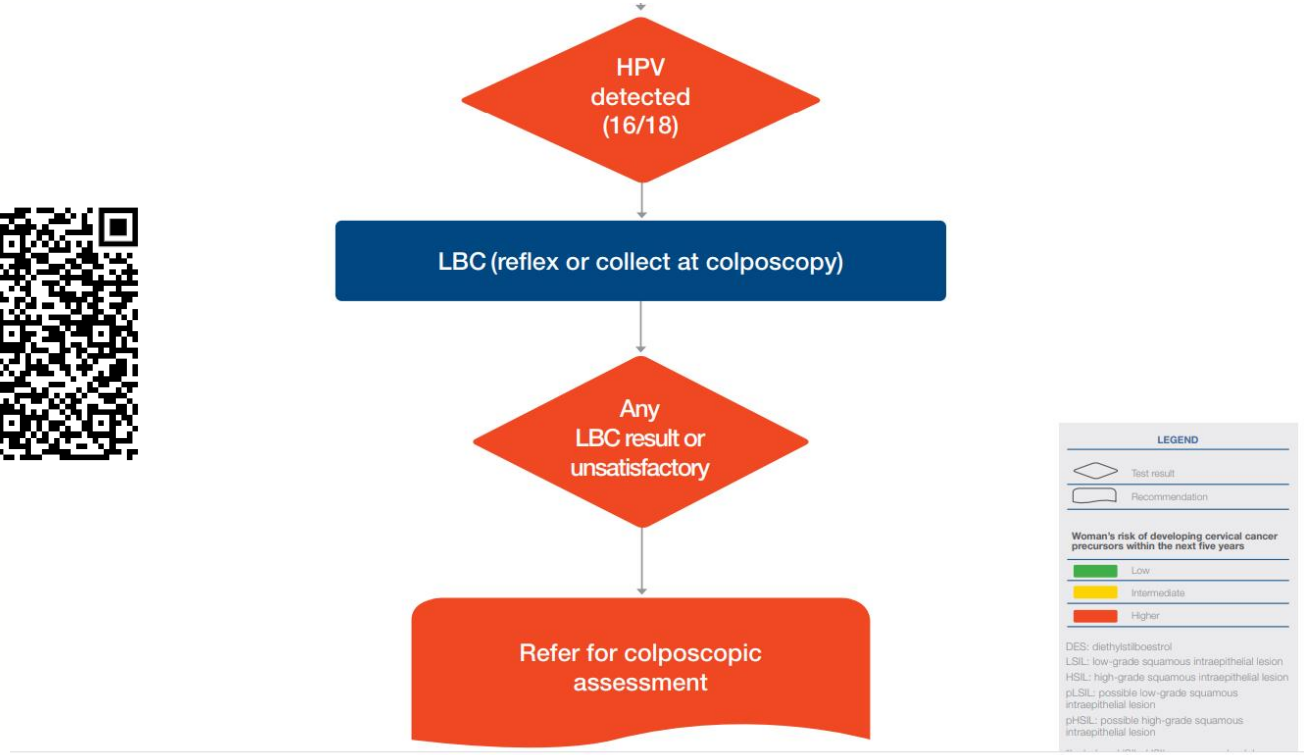
GUIDELINE UPDATES - This guideline was last updated 01/07/2022

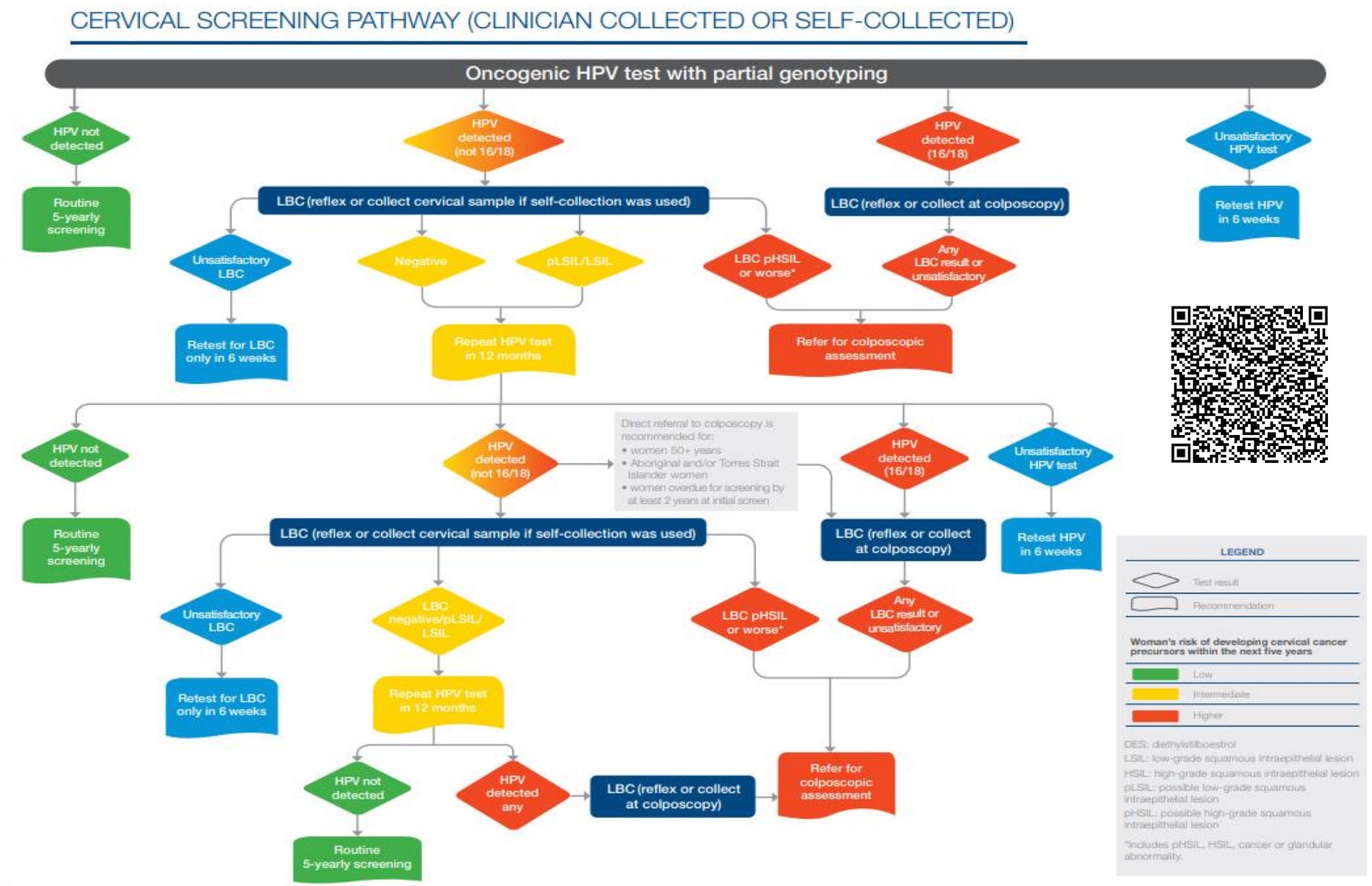
CLINICAL GUIDELINES SITEMAP

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





Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Cervical screening pathway. National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding. CCA 2016. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening. Updated Dec 2020.

NATIONAL CERVICAL SCREENING PROGRAM

Australian Government Department of Health

Cancer Council

Patients with positive non-16/18 but normal or LSIL on LBC would not need referral unless persistent on 2 further repeat CSTs (at 12 & 24 months)

If positive oncogenic HPV test result indicating presence of <u>both</u> HPV type 16 and/or 18 <u>and</u> other oncogenic HPV types (not 16 /18) - manage as for HPV types 16/18

Some HPV test platforms may provide additional information on other oncogenic HPV types (e.g. Type 31, 33 and/or 45). These HPV types should be considered as ‘oncogenic HPV (not 16/18) and women with these types should be managed accordingly.

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

- Invasive cervical cancer rates are low in women ≤ 25 years, even in completely unvaccinated populations. A substantial body of 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.
- 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 report
- Specific efforts should be made to provide screening for Aboriginal and Torres Strait Islander women (double the cervical cancer incidence)
- INCLUDE INFO HERE RE SELF COLLECT CST

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.

Indications for Colposcopy after abnormal CST

- Patients with positive non-16/18 but normal or LSIL on LBC would not need referral and only a repeat CST in 12 months. 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

Changes to the cervical screening intermediate risk pathway

This online module provides cervical screening providers with critical information about the change to the intermediate risk pathway within the National Cervical Screening Program.

Register Now

Cost	Fully funded
Delivery method	Self-paced, online
Who should register?	All non-medical and medical cervical screening providers
Eligibility	Past or current training in cervical screening

Course overview

This module details the change in the cervical screening intermediate risk pathway, which came into effect on 1 February 2021.

The module includes:

- Why the intermediate risk pathway changed
- Who is affected by the new intermediate risk pathway
- The new intermediate risk cervical screening pathway
- Management guidelines
- Case studies
- Quiz
- Resources

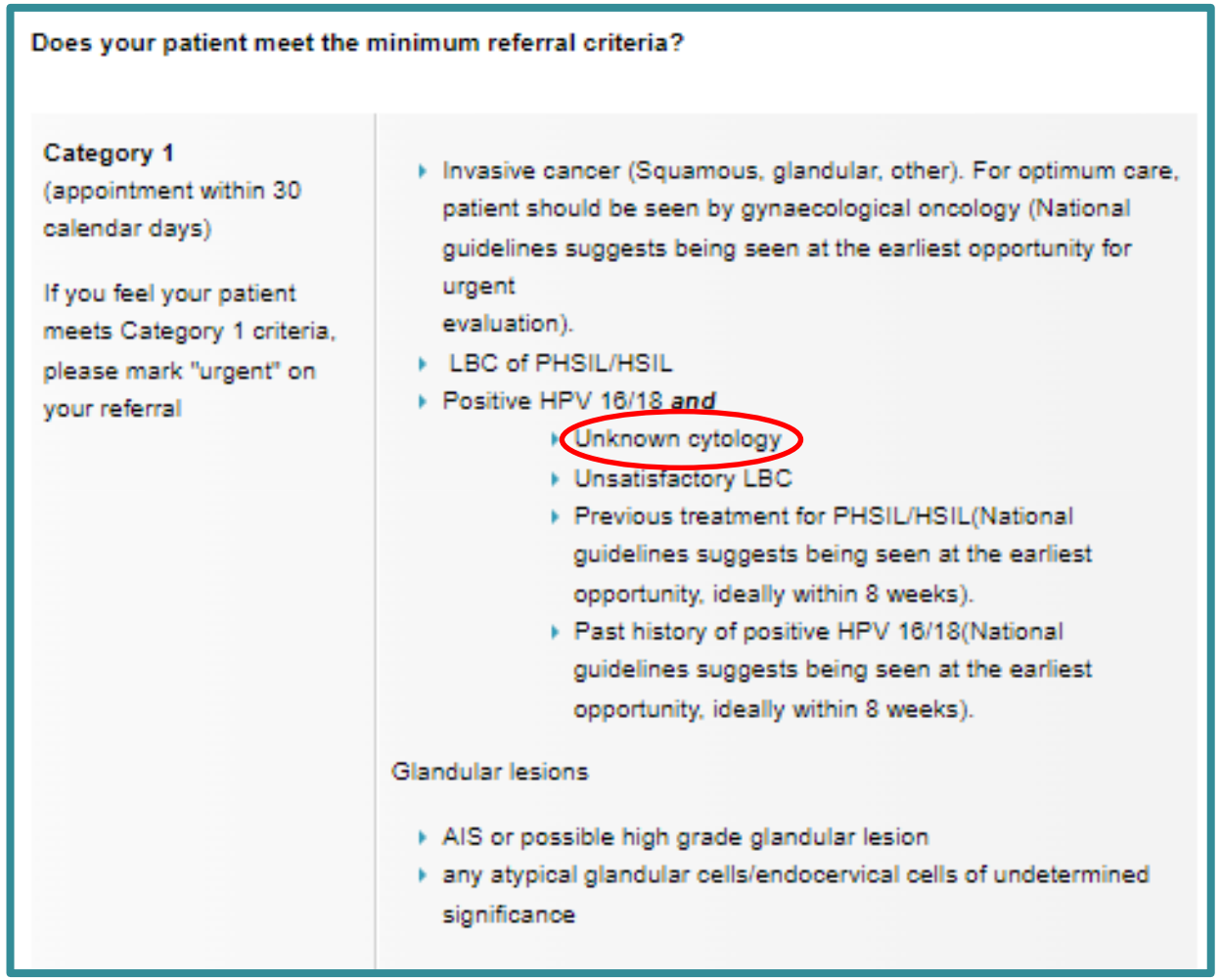
true relationships & reproductive health

GP Education module online – FREE

https://www.true.org.au/education/popular-links/full-course-catalogue/course-description/?eventtemplate=82-changes-to-the-cervical-screening-intermediate-risk-pathway

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)

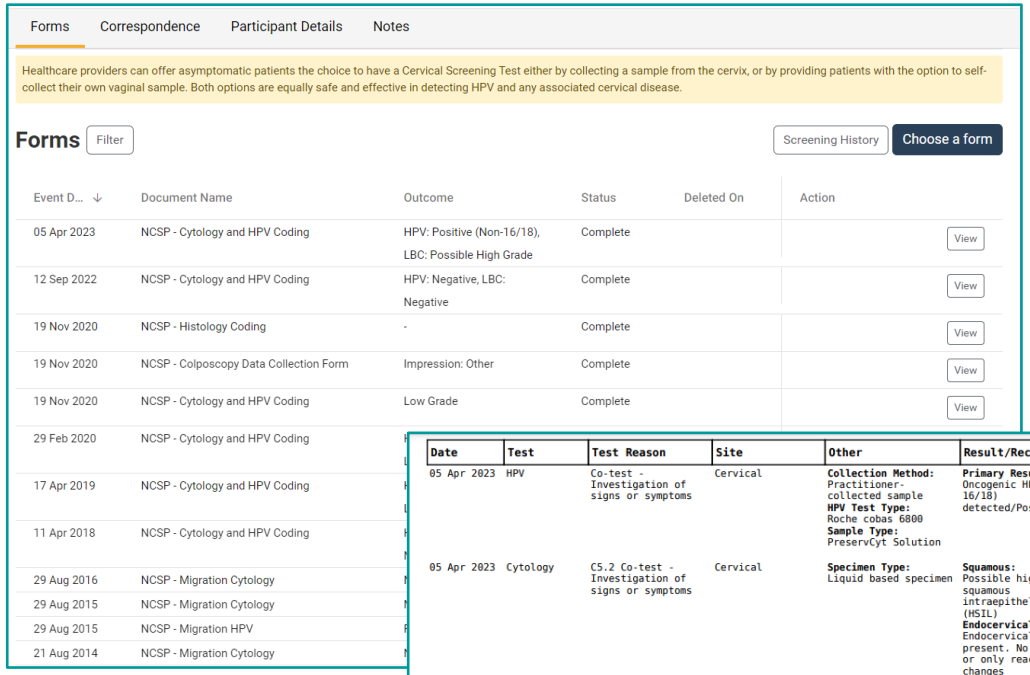
If a specific test result is unable to be obtained due to access, financial, religious, cultural or consent reasons a Clinical Override may be requested. This reason must be clearly articulated in the body of the referral.

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

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

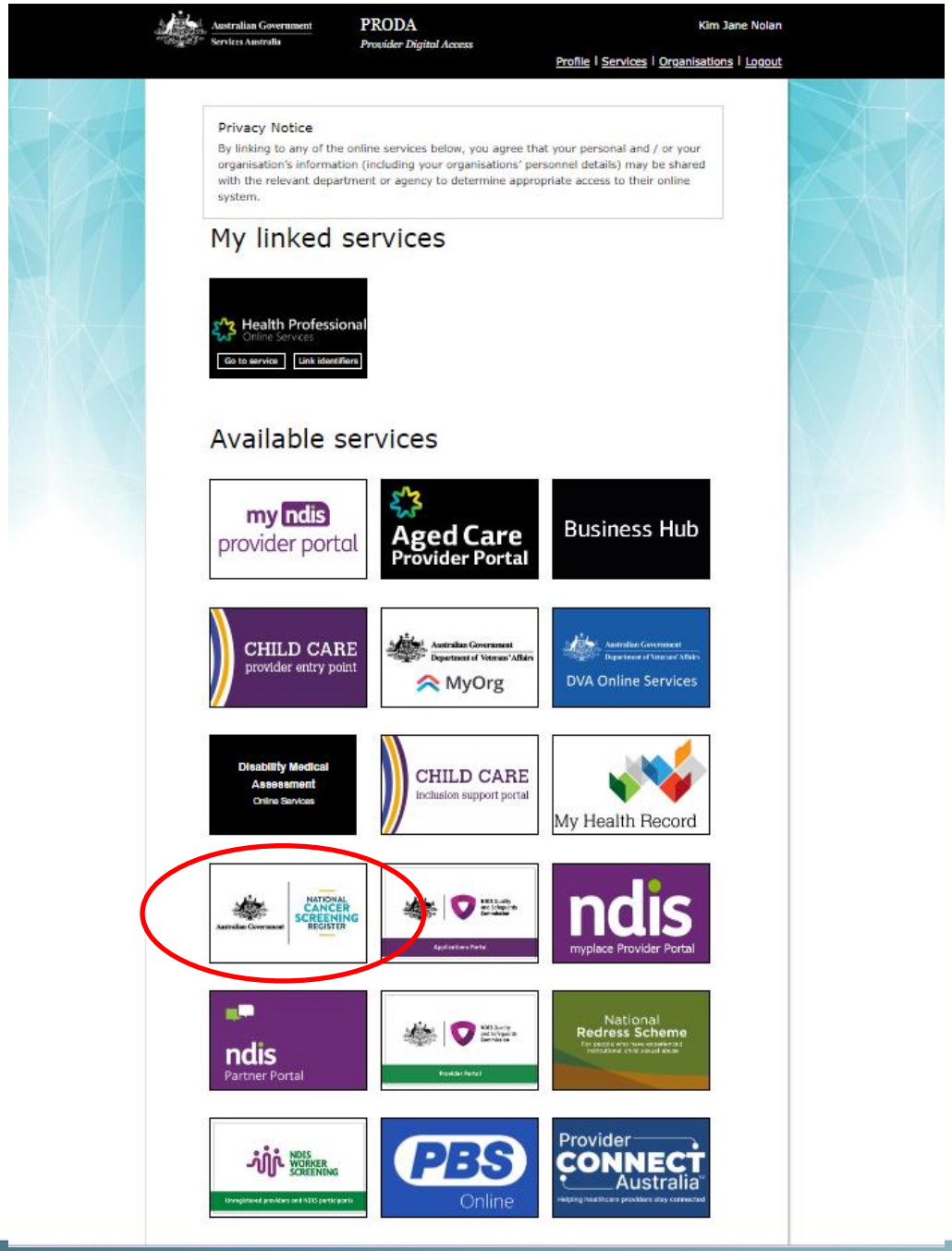
Event D...	Document Name	Outcome	Status	Deleted On	Action
05 Apr 2023	NCSP - Cytology and HPV Coding	HPV: Positive (Non-16/18), LBC: Possible High Grade	Complete		View
12 Sep 2022	NCSP - Cytology and HPV Coding	HPV: Negative, LBC: Negative	Complete		View
19 Nov 2020	NCSP - Histology Coding	-	Complete		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				

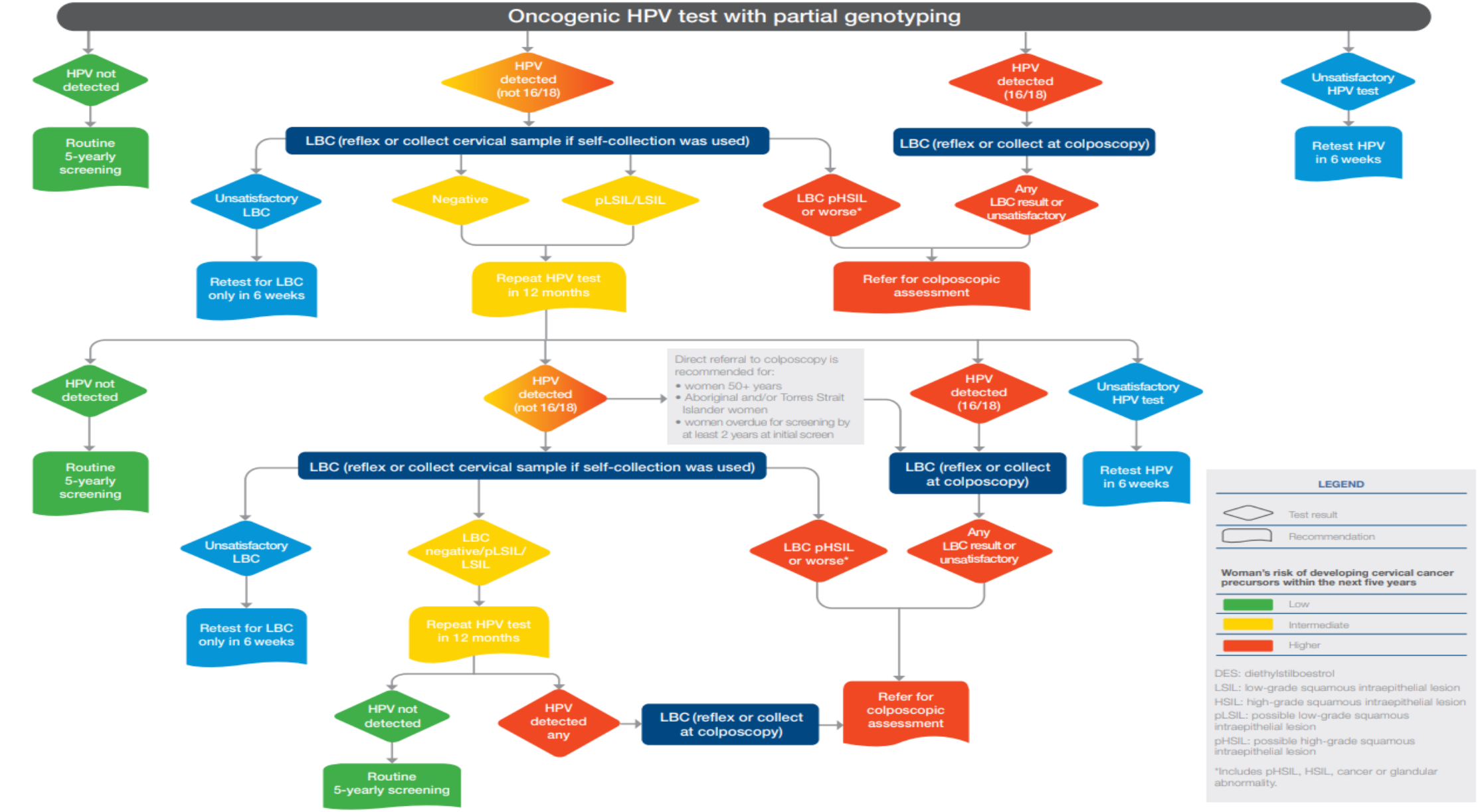
Date	Test	Test Reason	Site	Other	Result/Recommendation
05 Apr 2023	HPV	Co-test - Investigation of signs or symptoms	Cervical	**Collection Method:** Practitioner-collected sample **HPV Test Type:** Roche cobas 6800 **Sample Type:** PreservCyt Solution	**Primary Result:** Oncogenic HPV (not 16/18) detected/Positive 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





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NATIONAL CERVICAL SCREENING PROGRAM

Australian Government

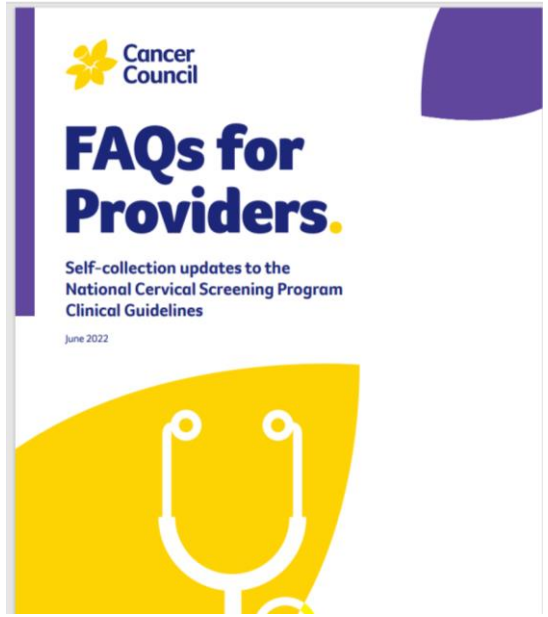
Cancer Council

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



How do I get a self-collection kit?

Talk to your laboratory for advice on the type of self-collection swab it supports or can process and to get advice on how to order the swabs.

Back to questions

What do patients need to know when I offer them self-collection of a vaginal sample?

Some key information for your patients includes the following:

- The test is just as accurate, regardless of whether they choose self-collection with the swab or clinician-collection with a speculum.
- They have the choice between self-collected vaginal samples and clinician-collected cervical samples.
- What will happen if HPV is detected, and how this differs for self-collected vaginal and clinician-collected cervical samples. For example:
  - If HPV16/18 is detected, colposcopy will be recommended (regardless of whether they choose self-collection or clinician-collection).
  - If HPV (not 16/18) is detected on a vaginal sample, they will generally need to return for a clinician-collected sample using a speculum, so that LBC can be done to guide further management, which could include colposcopy, or a repeat HPV test.
  - If HPV (not 16/18) is detected on a sample collected by a clinician using a speculum, LBC will automatically be done on the same sample, so in most cases, they won't need to return to have a separate sample taken (this might rarely happen if LBC is unsatisfactory)
  - In some cases, colposcopy referral is recommended for all patients with any HPV detected, regardless of the HPV type (and regardless of the type of sample). For example, if any HPV is detected in patients aged 70-74 who are attending for an exit test, in people living with HIV or who are immune-deficient, or in some patients attending for a follow-up test after a previous positive HPV test. In those cases, LBC is not required before colposcopy, even if their test was performed on a self-collected vaginal sample (a sample for LBC is collected at colposcopy).
- How likely it is HPV will be detected
  - Among those attending for a routine screening test, approximately 2% have HPV16/18 detected and approximately 6% have HPV (not 16/18) detected, although the latter varies by age. HPV is more commonly detected in those who are overdue and in younger people.
- What self-collection involves - how to collect the sample and return it
- Most people find it easy to collect the sample, but if they prefer, they can be assisted in using the swab or a provider can use the swab to collect the vaginal sample without a speculum.

Resources for patients are also available on the NCSP website

Back to questions

How can I learn more or access supporting materials to guide conversations with patients?

Resources to support providers are available on the NCSP website

Back to questions

national-cervical-screening-program-clinical-guidelines-faqs-for-providers (cancer.org.au)

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)

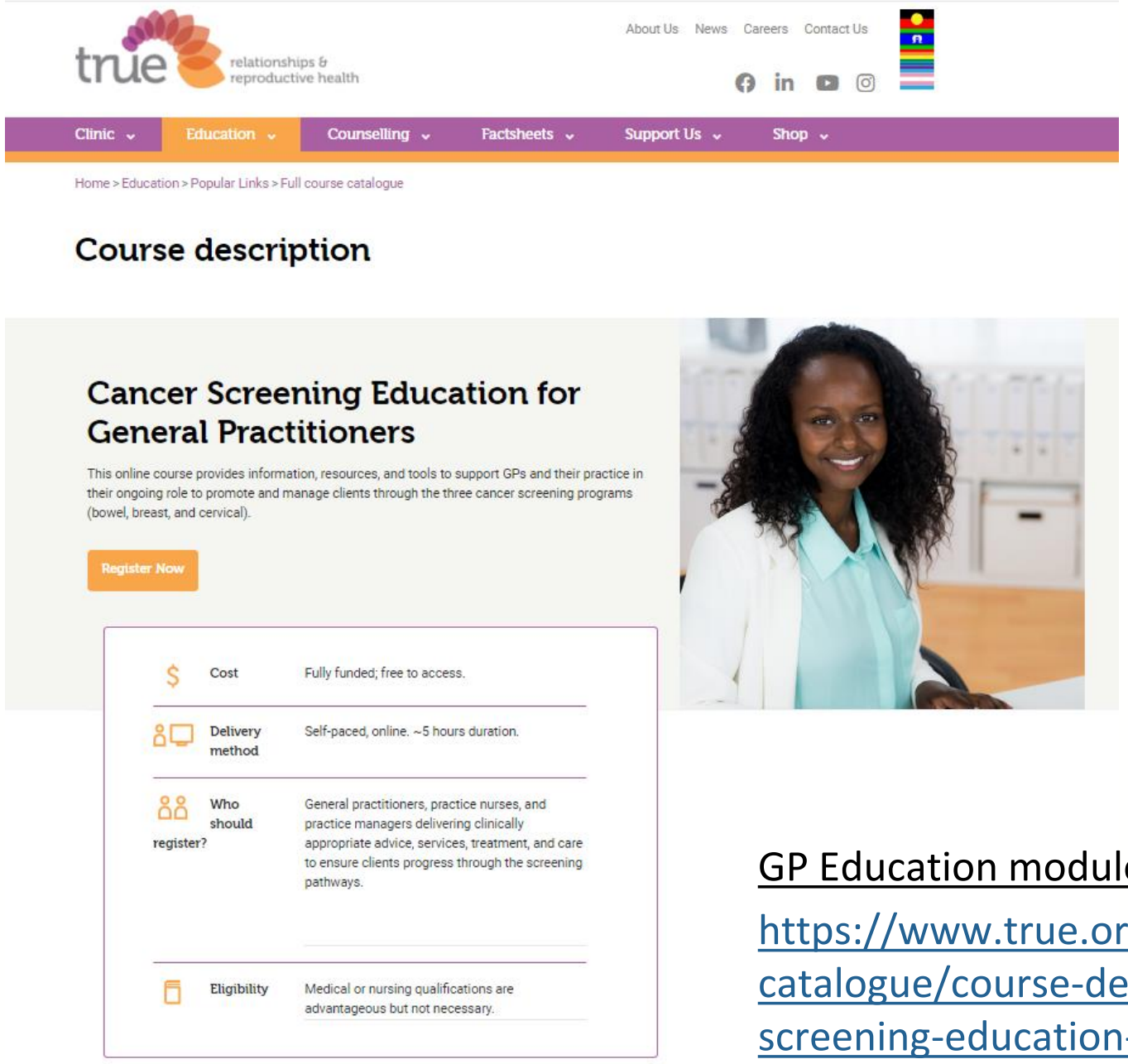
- In women who are vaccinated who may have pre-existing HPV infection, vaccine efficacy is lower than in HPV-naive women (reduced vaccine effectiveness among females who are already sexually active)

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)



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

Morning Tea

Session 2

Time	Session name	Presenter	Delivery
11.00 am	Case Discussion – Heavy Menstrual Bleeding	Group Spokesperson Dr Kim Nolan Dr Hasthika Ellepola	Facilitated groups Power Point Presentation & Forum Discussion
11:40 am	Case Discussion – Pelvic Floor Prolapse	Group Spokesperson Dr Hasthika Ellepola	Facilitated groups Power Point Presentation & Forum Discussion
12:10 am	Case Discussion – Incontinence	Group Spokesperson Dr Kim Nolan Dr Sanja Savic	Facilitated groups Power Point Presentation & Forum Discussion
12:40 noon	Physiotherapy Management of Prolapse, Urinary and Faecal incontinence; Physiotherapy Pelvic Health Service in MSHHS	Melanie Walkenhorst	Practical Demonstration ALL
1:00 pm	LUNCH	ALL	ALL

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

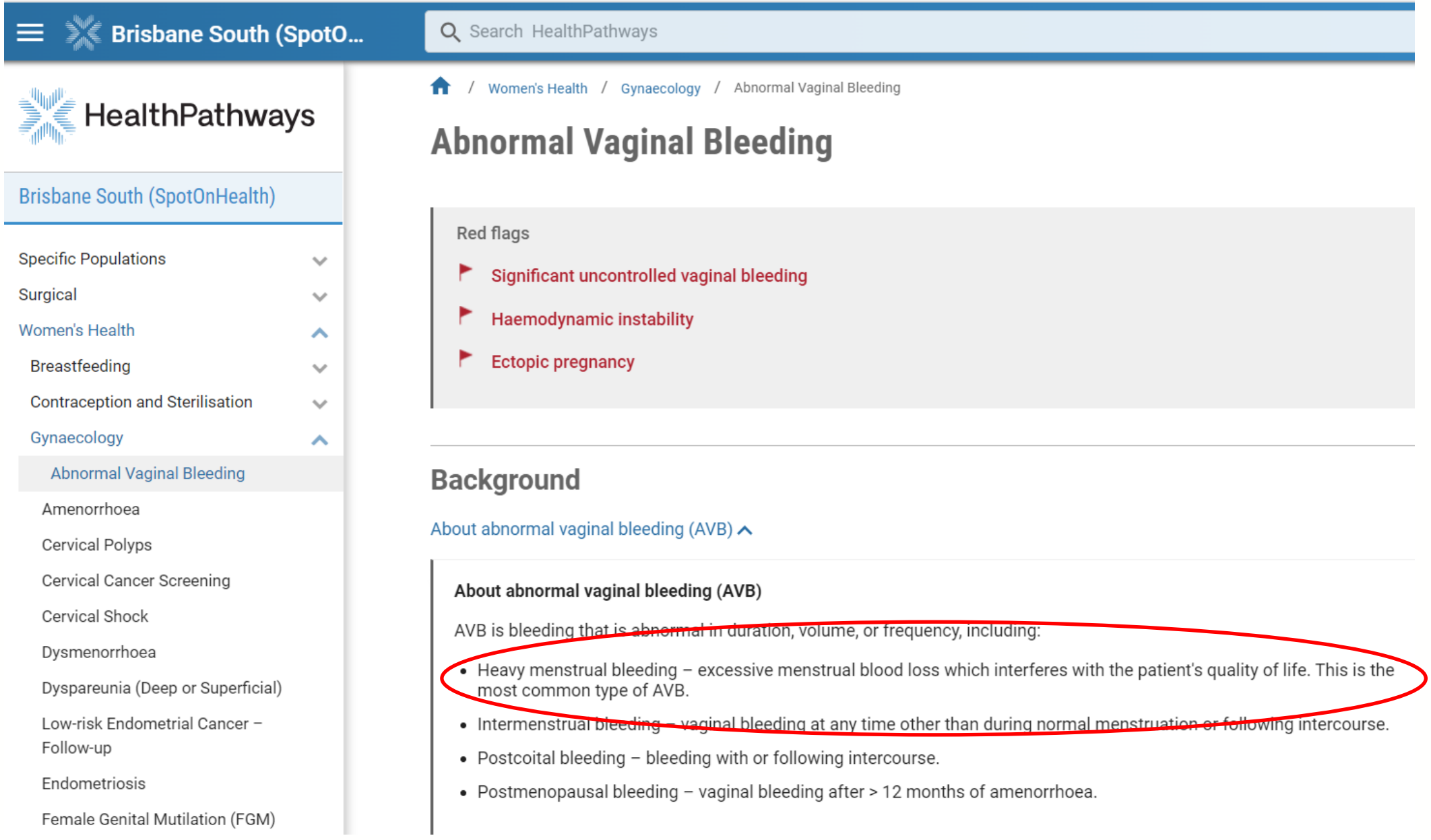
Heavy Menstrual Bleeding

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 1/3 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

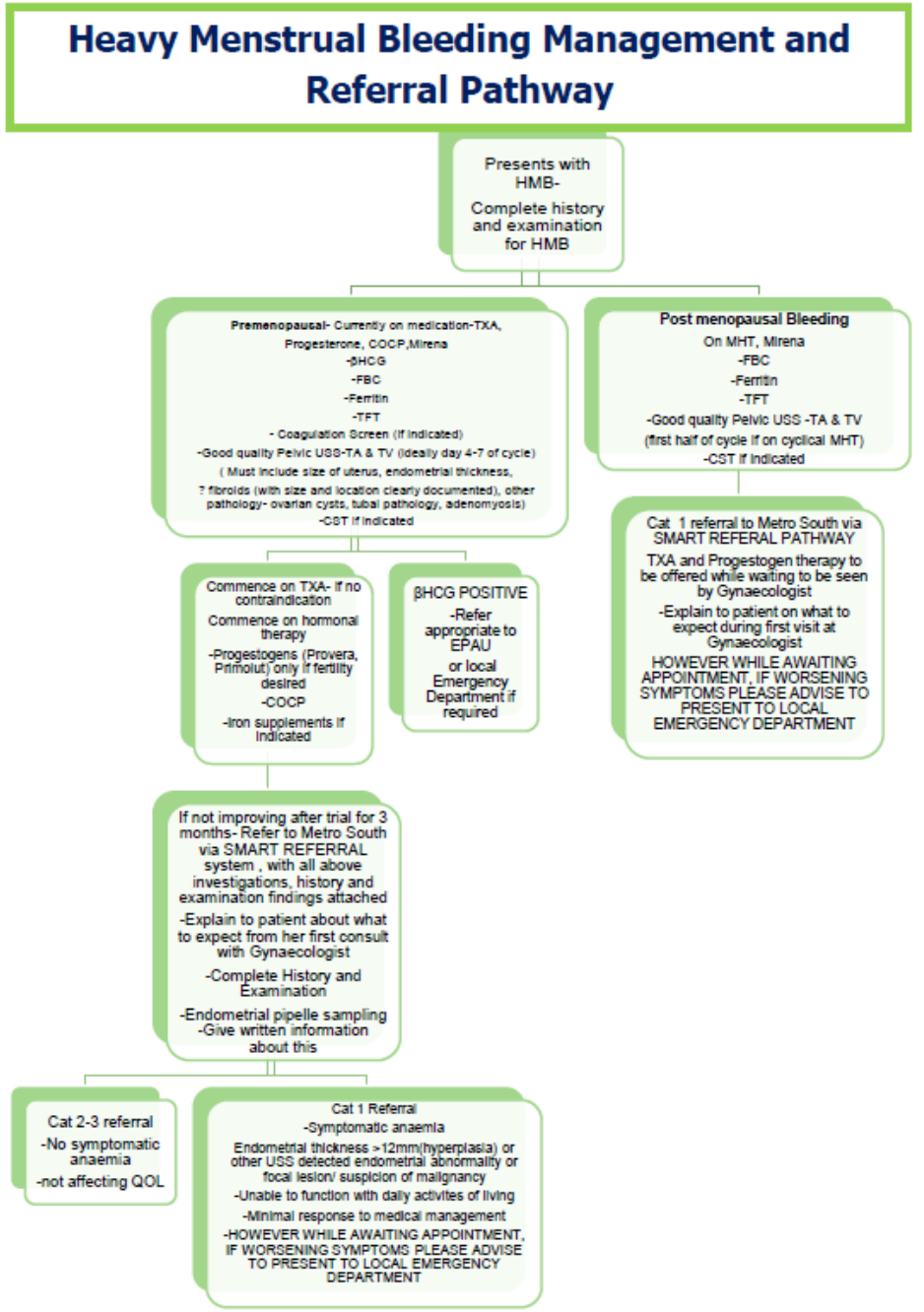
Examine the patient:

- 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.

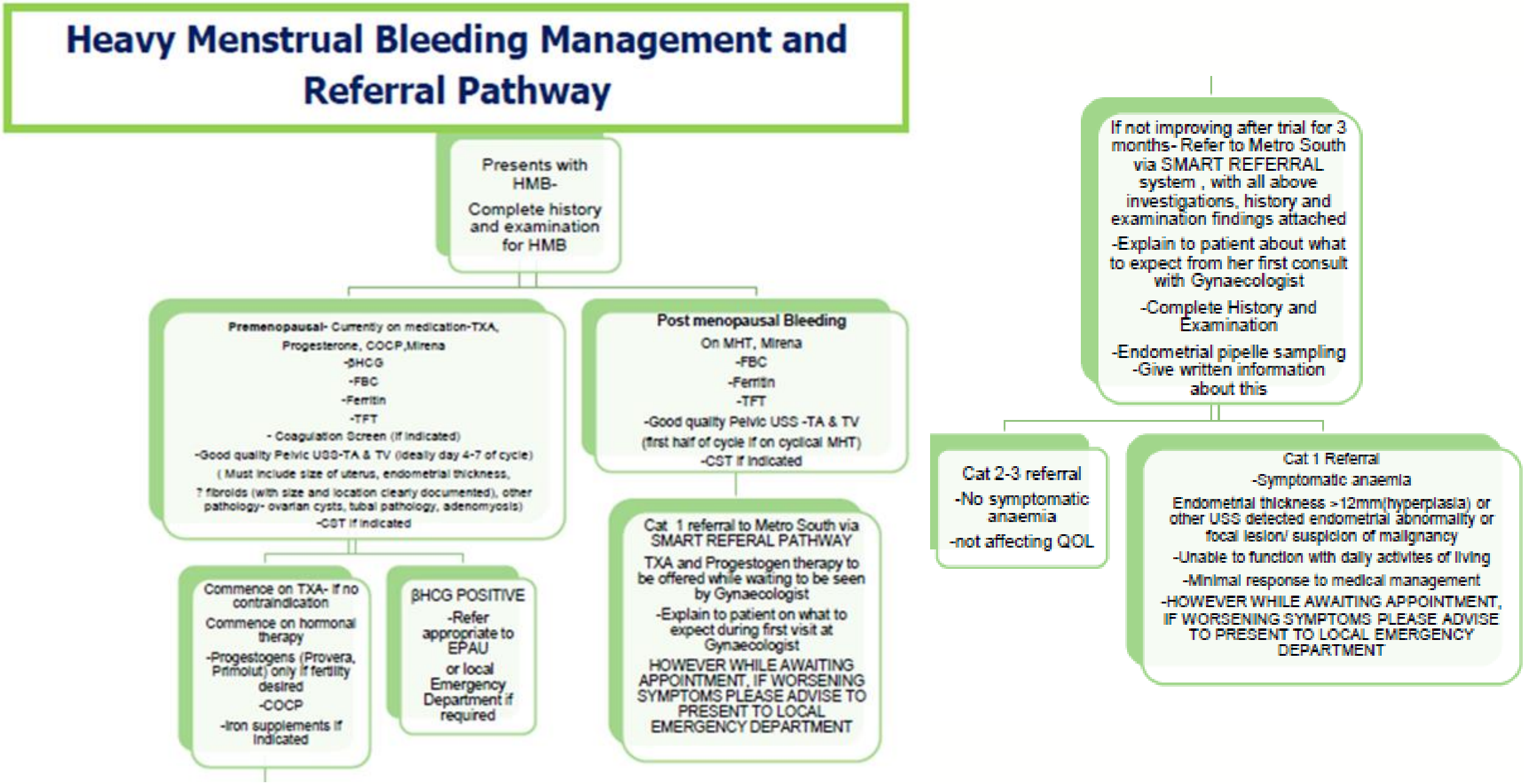
Investigations:

- 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:

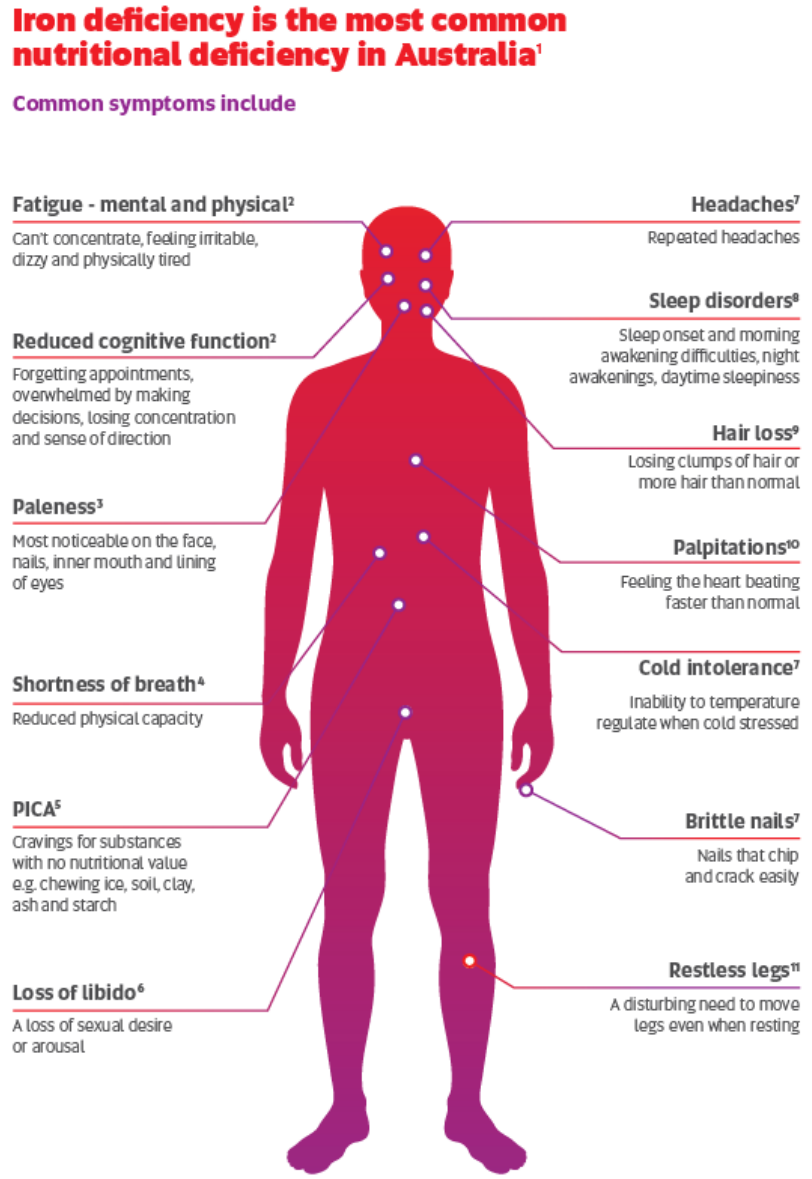
Suspect if:

- 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

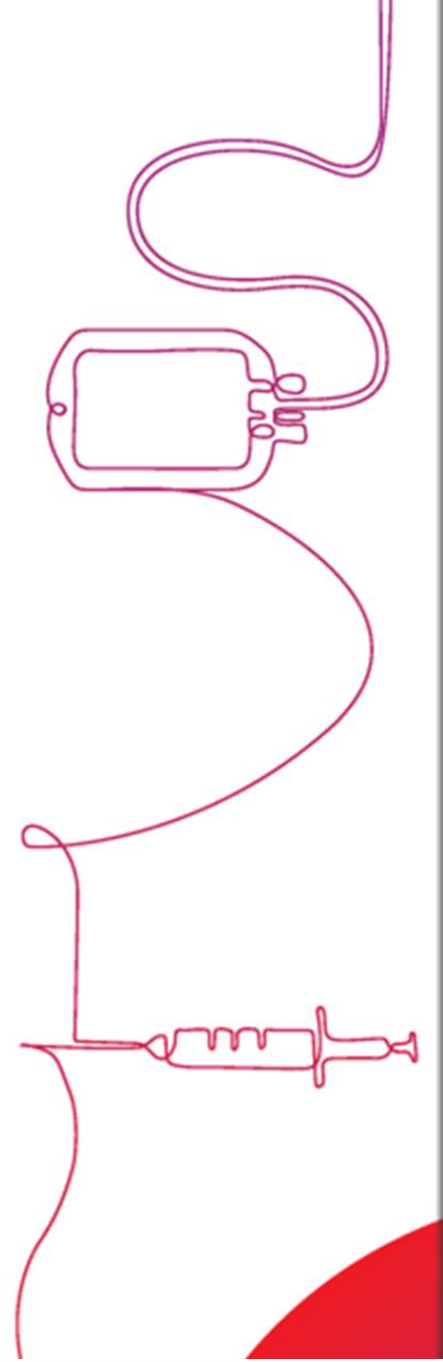
See the relevant pathway for details – Intravenous Iron Infusion

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

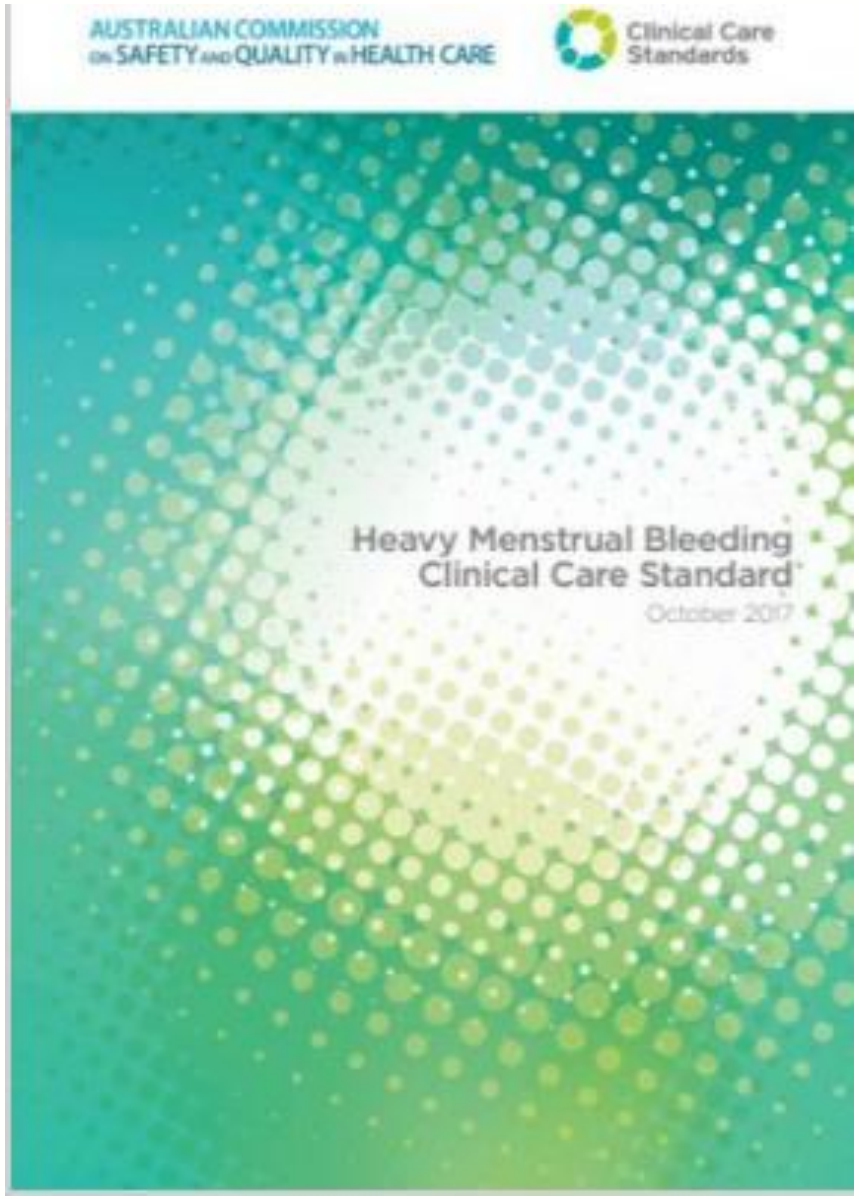
STRUCTURAL - can be identified /measured by imaging +/- histopathology

Coagulopathy
Ovulatory dysfunction
Endometrial
Iatrogenic
Not otherwise classified

NON- STRUCTURAL cannot defined by imaging or histopathology

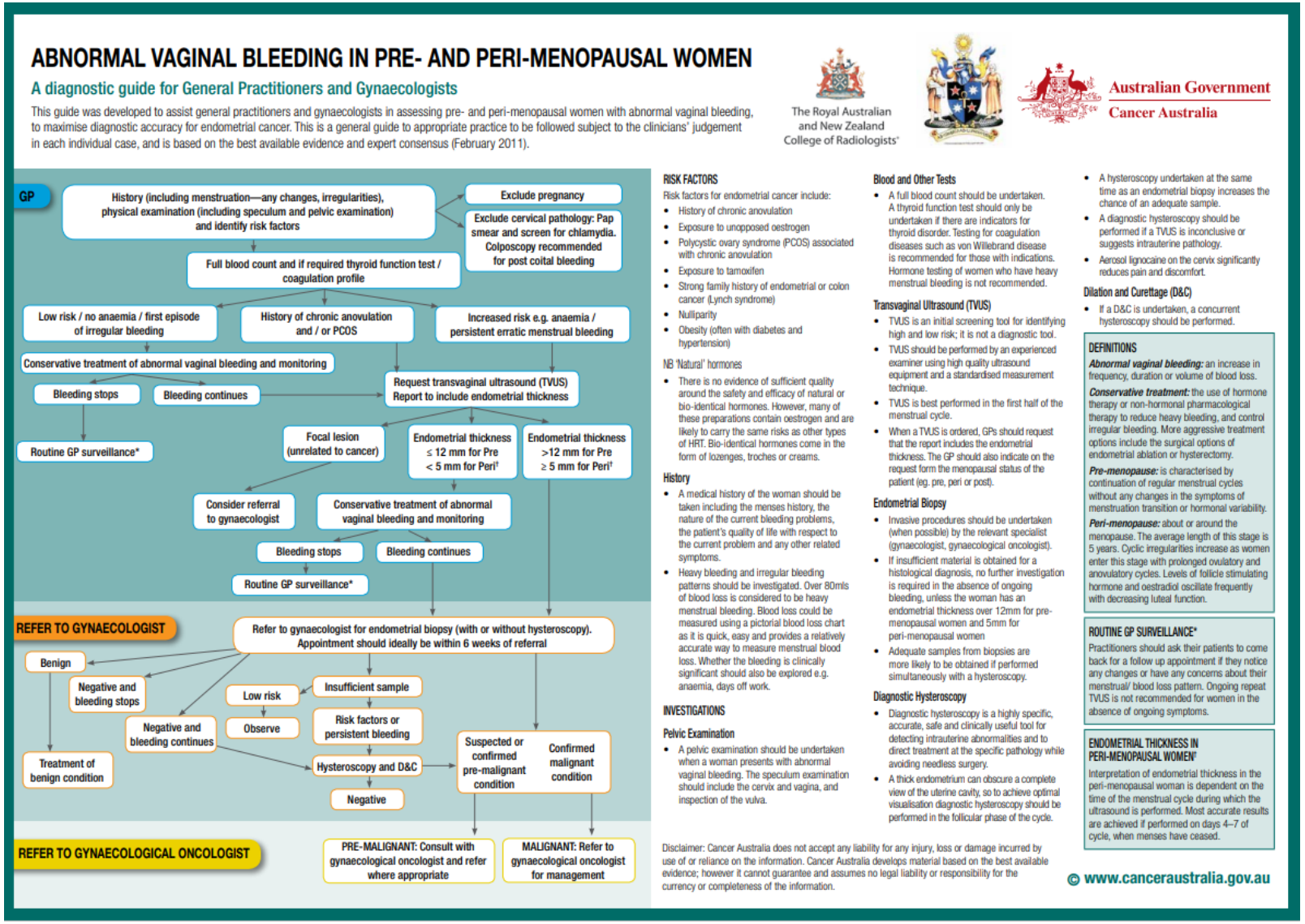
FIGO classification system (PALM-COEIN) for causes of abnormal uterine bleeding in nongravid women of reproductive age - International Journal of Gynecology and Obstetrics 113 (2011) 3-13

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



Heavy Menstrual Bleeding Clinical Care Standard published in 2017 to ensure currency with relevant guidelines and clinical practice.

The revised Standard is expected to be published in early 2024, and has been out for review since late 2023



https://www.canceraustralia.gov.au/sites/default/files/publications/abnormal-vaginal-bleeding-pre-peri-and-post-menopausal-women-diagnostic-guide-general-practitioners/pdf/ncgc_a3_menopause_chart_june_2012_final.pdf

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 Hasthika Ellepola
Deputy Director Gynaecology
Obstetrics and Gynaecology Department
Logan Hospital

ICARE² values

INTEGRITY COMPASSION ACCOUNTABILITY RESPECT ENGAGEMENT EXCELLENCE

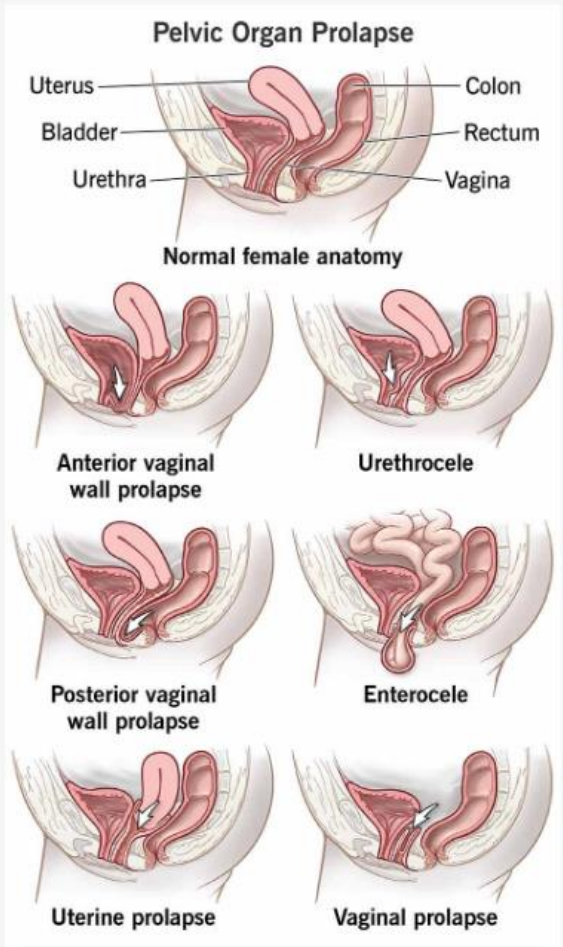
Queensland Government

Prolapse = Prolapsus (Latin) – "a slipping forth”

Prolapse is a hernia, with the hernial portal being the ‘levator hiatus’
(i.e. the opening in the pelvic floor muscle or ‘levator ani’, which allows for vaginal childbirth, and subsequently the urethra, vagina and/or anorectum to transit the abdominal envelope).

Aetiology: uncertain

- ? fascial defects caused by vaginal childbirth – major trauma seen in 10-20 % primiparae after NVD/Vacuum extraction with 30–65% after forceps
- ? pudendal nerve trauma weakening levator ani
- obesity esp. for posterior compartment
- Ageing and oestrogen deficiency, although vaginal atrophy and urogenital involution oppose this in part
- chronically raised intra-abdominal pressure – e.g., asthma/COPD,
- constipation, heavy lifting
- ? Genetics ? Related to collagen subtypes, but not conclusive research except in Ehlers Danlos Syndrome and confirmed connective tissue disorders
- VAGINAL CHILDBIRTH – predominate causative factor, increased by multiple deliveries, multiple births and macrosomia



Prolapse Symptoms

Vaginal:

- Vaginal fullness or bulge
- Dragging sensation
- Pelvic pressure or discomfort
- Vaginal laxity/looseness
- Dyspareunia
- Difficulty with intercourse, loss of arousal
- Vaginal spotting (in the presence of ulceration of the prolapse)
- Vaginal dryness, irritation, itching or persistent smelly discharge suggestive of genitourinary syndrome of menopause (previously known as atrophic vaginitis)

Urinary:

- Frequency, urgency, nocturia, incontinence
- Straining to void or intermittent stream (urethral kinking)
- Incomplete emptying
- Slow or intermittent stream
- Recurrent UTIs (3 or more in 1 year)

Bowel:

- Straining to defecate
- Obstructed defecation
- Incomplete emptying
- Patient needs to digitally reduce the prolapse in order to open bowels

Prolapse - Community HealthPathways Brisbane South (SpotOnHealth)

AUSTRALIAN PELVIC FLOOR QUESTIONNAIRE

Patient's Name: _____

Date of Birth: _____

Date completed: _____

Please circle your most applicable answer. Consider your experience during the last month.

BLADDER FUNCTION (____/ 45)

Q1. How many times do you pass urine in a day?
0 Up to 7
1 Between 8-10
2 Between 11-15
3 More than 15

Q2. How many times do you get up at night to pass urine?
0 0-1
1 2
2 3
3 More than 3 times

Q3. Do you wet the bed before you wake up at night?
0 Never
1 Occasionally - less than once per week
2 Frequently - once or more per week
3 Always - every night

Q4. Do you need to rush/hurry to pass urine when you get the urge?
0 Can hold on
1 Occasionally have to rush – less than once/week
2 Frequently have to rush – once or more/week
3 Daily

Q5. Does urine leak when you rush or hurry to the toilet or can't you make it in time?
0 Not at all
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q6. Do you leak with coughing, sneezing, laughing or exercising?
0 Not at all
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q7. Is your urinary stream (urine flow) weak, prolonged or slow?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q8. Do you have a feeling of incomplete bladder emptying?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q9. Do you need to strain to empty your bladder?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q10. Do you have to wear pads because of urinary leakage?
0 None - Never
1 As a precaution
2 When exercising / during a cold
3 Daily

Q11. Do you limit your fluid intake to decrease urinary leakage?
0 Never
1 Before going out
2 Moderately
3 Always

Q12. Do you have frequent bladder infections?
0 No
1 1-3 per year
2 4-12 per year
3 More than one per month

Q13. Do you have pain in your bladder or urethra when you empty your bladder?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q14. Does urine leakage affect your routine activities like recreation, socializing, sleeping, shopping etc?
0 Not at all
1 Slightly
2 Moderately
3 Greatly

Q15. How much does your bladder problem bother you?
0 Not at all
1 Slightly
2 Moderately
3 Greatly

Other symptoms (haematuria, pain etc.)

_____

_____

BOWEL FUNCTION (____/ 34)

Q16. How often do you usually open your bowels?
0 Ever other day or daily
1 Less than every 3 days
2 Less than once a week
0 More than once per day

Q17. How is the consistency of your usual stool?
0 Soft
0 Firm
0 Hard (pebbles)
1 Variable
2 Watery

Q18. Do you have to strain to empty your bowels?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q19. Do you use laxatives to empty your bowels?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q20. Do you feel constipated?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q21. When you get wind or flatus, can you control it, or does wind leak?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

AUSTRALIAN PELVIC FLOOR QUESTIONNAIRE

AUSTRALIAN PELVIC FLOOR QUESTIONNAIRE

Patient's Name: _____

Date of Birth: _____

Date completed: _____

Q22. Do you get an overwhelming sense of urgency to empty bowels?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q23. Do you leak watery stool when you don't mean to?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q24. Do you leak normal stool when you don't mean to?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q25. Do you have a feeling of incomplete bowel emptying?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q26. Do you use finger pressure to help empty your bowel?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q27. How much does your bowel problem bother you?
0 Not at all
1 Slightly
2 Moderately
3 Greatly

PROLAPSE SYMPTOMS (____/15)

Q28. Do you have a sensation of tissue protrusion/lump/bulging in your vagina?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q29. Do you experience vaginal pressure or heaviness or a dragging sensation?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q30. Do you have to push back your prolapse in order to void?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q31. Do you have to push back your prolapse to empty your bowels?
0 Never
1 Occasionally – less than once per week
2 Frequently – once or more per week
3 Daily

Q32. How much does your prolapse bother you?
0 Not at all
1 Slightly
2 Moderately
3 Greatly

Other Symptoms: (problems: walking / sitting, pain, vaginal bleeding)

_____

_____

_____

SEXUAL FUNCTION (____/21)

Q33. Are you sexually active?
□ No
□ Less than once per week
□ Once or more per week
□ Daily or most days

If you are not sexually active, please continue to answer questions 34 & 42.

Q34. If you are not sexually active, please tell us why?
□ Do not have a partner
□ I am not interested
□ My partner is unable
□ Vaginal dryness
□ Too painful
□ Embarrassment due to the prolapse/incontinence
□ Other reasons: _____

Q35. Do you have sufficient vaginal lubrication during intercourse?
0 Yes
1 No

Q36. During intercourse vaginal sensation is:
0 Normal / pleasant
1 Minimal
1 Painful
3 None

Q37. Do you feel that your vagina is too loose or lax?
0 Never
1 Occasionally
2 Frequently
3 Always

Q38. Do you feel that your vagina is too tight?
0 Never
1 Occasionally
2 Frequently
3 Always

Q39. Do you experience pain with sexual intercourse?
0 Never
1 Occasionally
2 Frequently
3 Always

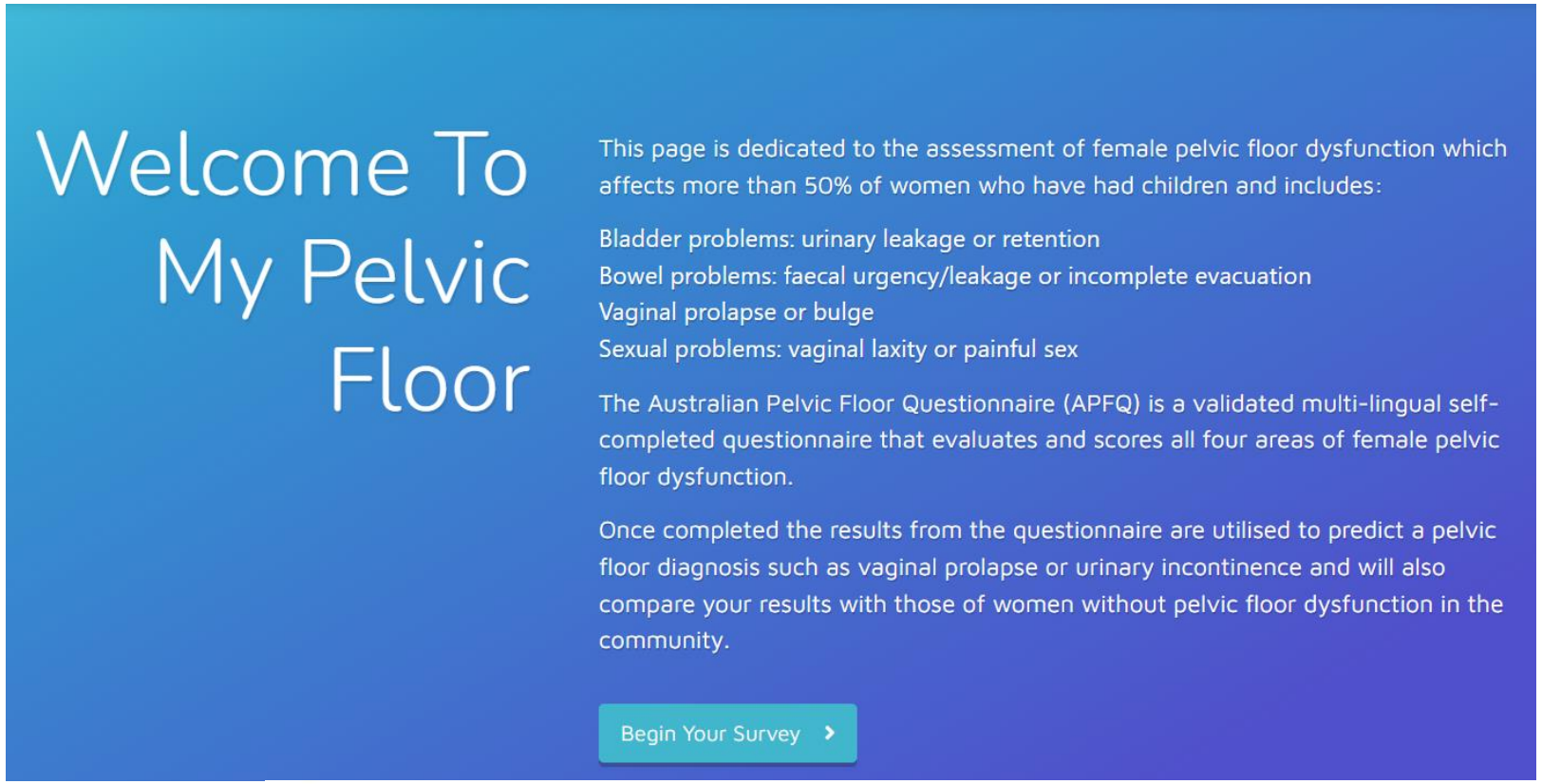
Q40. Where does the pain during intercourse occur?
0 Not applicable, I do not have pain
1 At the entrance to the vagina
1 Deep inside, in the pelvis
2 Both at the entrance & in the pelvis

Q41. Do you leak urine during sexual intercourse?
0 Never
1 Occasionally
2 Frequently
3 Always

Q42. How much do these sexual issues bother you?
□ Not applicable
0 Not at all
1 Slightly
2 Moderately
3 Greatly

Q43. Other symptoms?
(faecal incontinence, vaginismus etc)

[australian-pelvic-floor-questionnaire-V2018.pdf (urogynaecology.com.au) - AUSTRALIAN PELVIC FLOOR QUESTIONNAIRE]



Patients can access an online Australian Pelvic Floor Questionnaire (APFQ) : validated multi-lingual self-completed questionnaire that evaluates and scores all four areas of female pelvic floor dysfunction. https://www.mypelvicfloor.com/

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

TREATMENT OPTIONS FOR

Pelvic Organ Prolapse

What is pelvic organ prolapse?

Pelvic organs include your bladder, womb (uterus) and rectum. Pelvic organ prolapse occurs when one or more of these organs bulges against, or sags down into the vagina and the muscles and ligaments in the pelvic floor become stretched, or too weak to hold the organs in the correct place.

Prolapse can occur in the front wall of the vagina (cystocele), back wall of the vagina (rectocele), uterus (uterine) or top of the vagina (vault). You can have prolapse of more than one organ at the same time. Types of prolapse are shown on page 6.

Vaginal prolapse is common, affecting up to half of adult women[1]. Causes include pregnancy and childbirth, aging and menopause, obesity, chronic cough, chronic constipation, and heavy lifting. Prolapse can also occur following hysterectomy and other pelvic surgeries.

Prolapse is usually not life-threatening, but it can significantly affect your quality of life. It's your choice how you proceed.

[1] Lifetime risk of undergoing surgery for pelvic organ prolapse. Smith FJ, Holman CDJ, Moorin RE, Tsokos N, Obstet Gynecol 2010; 116,5:1096-1100

What are the symptoms of pelvic organ prolapse?

You might have:

- Pressure or bulging in your vagina, often made worse with physical activities
- Painful intercourse, or less sensation with intercourse
- Less control with your bladder or bowels
- Urinary problems such as retention (unable to urinate when your bladder is full), incontinence, and urinary tract infection
- In severe cases of prolapse obstruction of the ureters (the tubes which connect the kidneys to the bladder) and kidney function impairment can occur.

These symptoms can contribute to physical impacts and affect your quality of life. If you have no symptoms, or your symptoms don't affect your usual activities, you may safely choose to do nothing at all.

Information for consumers

This guide is designed to help you discuss treatment options for vaginal pelvic organ prolapse with your health professional and to share decisions about your care.

About this guide

The Australian Commission on Safety and Quality in Health Care (the Commission) 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 also considers the decision by the Therapeutic Goods Administration (TGA), to remove transvaginal mesh products where sole use is the treatment of prolapse via transvaginal implantation from the Australian Register of Therapeutic Goods (ARTG) from 4 January, 2018.

[See Understanding the Risks of Transvaginal Mesh on Page 7].

What are my treatment options?

There are different ways that prolapse can be treated. It depends on how much of a problem your prolapse is to your quality of life.

Your options fall into three categories:

1. **Do nothing**
2. **Non-surgical treatments**
   Lifestyle changes, pelvic floor exercises, vaginal pessary, oestrogen cream
3. **Surgical treatments**
   Native tissue repair, synthetic mesh repair

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

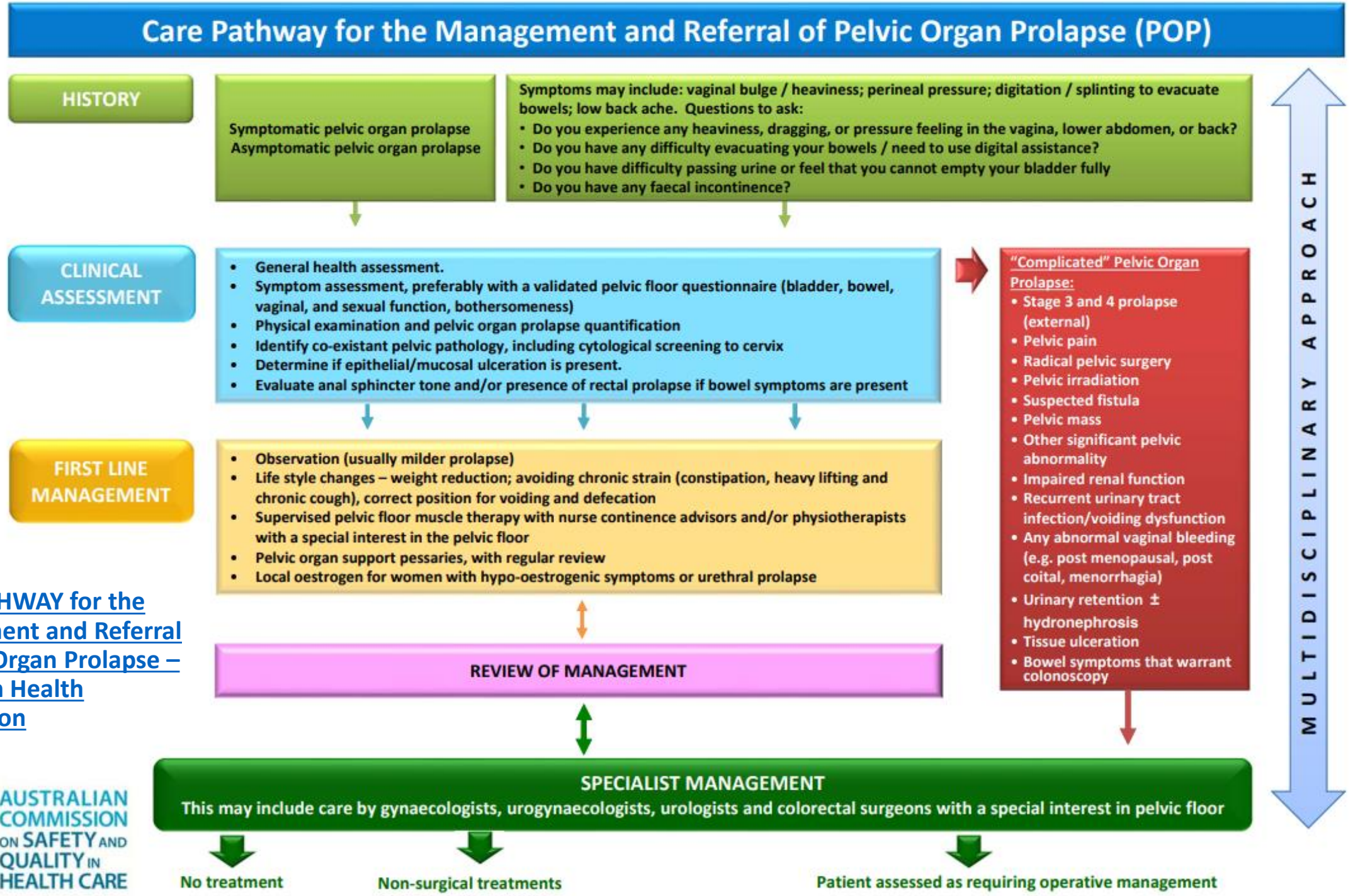
1 Do nothing – no treatment

After considering information about your prolapse, you may decide not to have any treatment. The prolapse may worsen with time, but treatment can then be considered and undertaken later.

You might have both prolapse and incontinence present at the same time, but these are separate conditions and each needs to be assessed and specific treatment options for stress urinary incontinence should be considered. The Commission has another information resource to inform your options about stress urinary incontinence.

https://www.safetyandquality.gov.au/sites/default/files/2020-01/treatment_options_for_pelvic_organ_prolapse_pop_-_transvaginal_tv_mesh_-_information_for_consumers_patient_resource.pdf

Care Pathway for the Management and Referral of Pelvic Organ Prolapse (POP)



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

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

RED FLAG

Require more urgent Urology/Gynaecologist review

"Complicated" Pelvic Organ Prolapse:

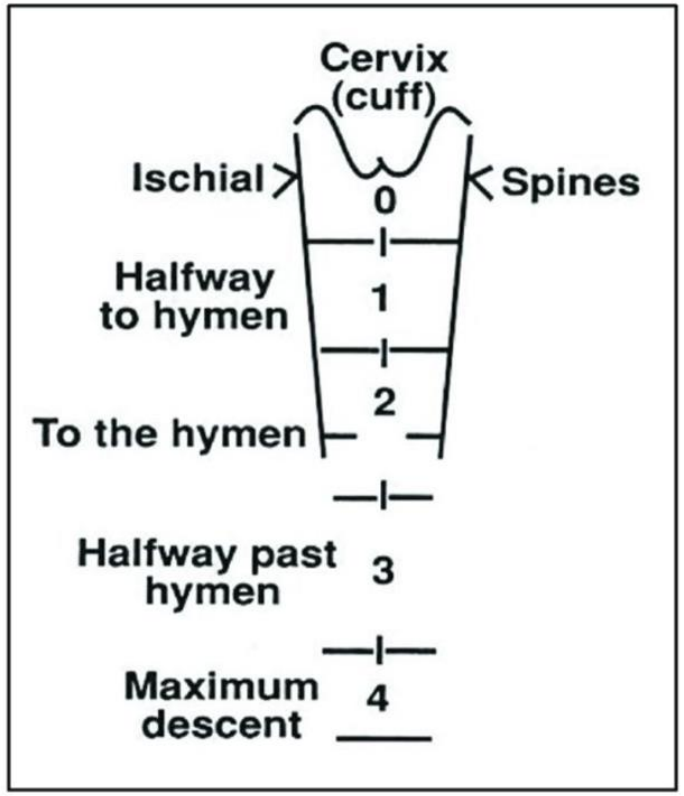
- Stage 3 and 4 prolapse (external)
- Pelvic pain
- Radical pelvic surgery
- Pelvic irradiation
- Suspected fistula
- Pelvic mass
- Other significant pelvic abnormality
- Impaired renal function
- Recurrent urinary tract infection/voiding dysfunction
- Any abnormal vaginal bleeding (e.g. post menopausal, post coital, menorrhagia)
- Urinary retention ± hydronephrosis
- Tissue ulceration
- Bowel symptoms that warrant colonoscopy

Prolapse – Clinical Assessment

- Grading of prolapse –

  determining the position of leading edge* of the prolapse (i.e. most dependent part) in relation to the hymen & with patient straining (i.e. coughing or performing Valsalva manoeuvre).

  - Baden-Walker System
  - POP-Q
  - Other
- MSU M/C/S
- Pelvic/transvaginal USS – CONSIDER

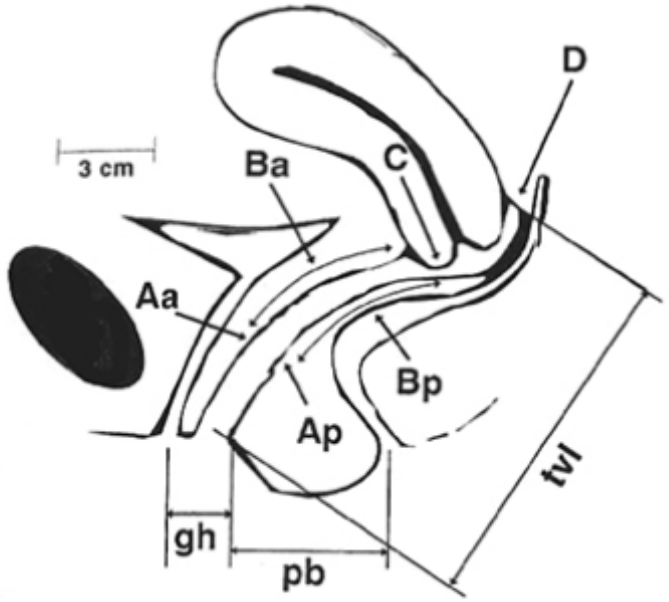


Baden-Walker System

- Stage 1 – * > 1 cm above the hymen.
- Stage 2 – * between 1 cm above or 1 cm below the hymen
- Stage 3 – * > 1 cm below the hymen.
- Stage 4 – complete prolapse (procidentia)

Prolapse Grading – POP-Q

Clinical diagnosis



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**

Figure 1. Prolapse assessment using the prolapse quantification system of the International Continence Society (POP-Q)

To simplify the task, many clinicians limit themselves to Ba for the leading edge of anterior prolapse, C for the leading edge of uterine or vault prolapse, Bp for the leading edge of posterior prolapse and tvl. The distance from external urethral meatus to anus (gh + pb) seems to be a good measure of 'ballooning' or hiatal distensibility[58]

Reproduced with permission from Elsevier from Bump RC, Mattiasson A, Bø K, et al. Am J Obstet Gynecol 1996;175:10–17

RACGP - Pelvic organ prolapse – a review - https://www.racgp.org.au/afp/2015/july/pelvic-organ-prolapse-a-review

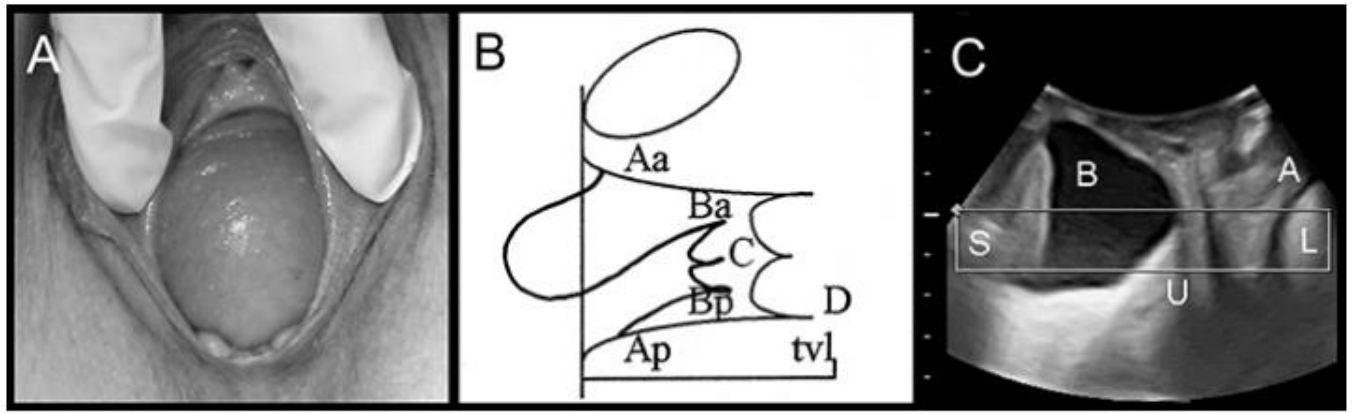


Figure 2. Anterior compartment prolapse
(A) Cystocele on clinical photograph
(B) Representation on POP-Q: Ba or leading edge of the anterior vaginal wall = +3, C = −4, Bp = −3)
(C) Appearances on imaging: S, symphysis pubis; B, bladder; U, uterus; A, anal canal, L= levator ani)

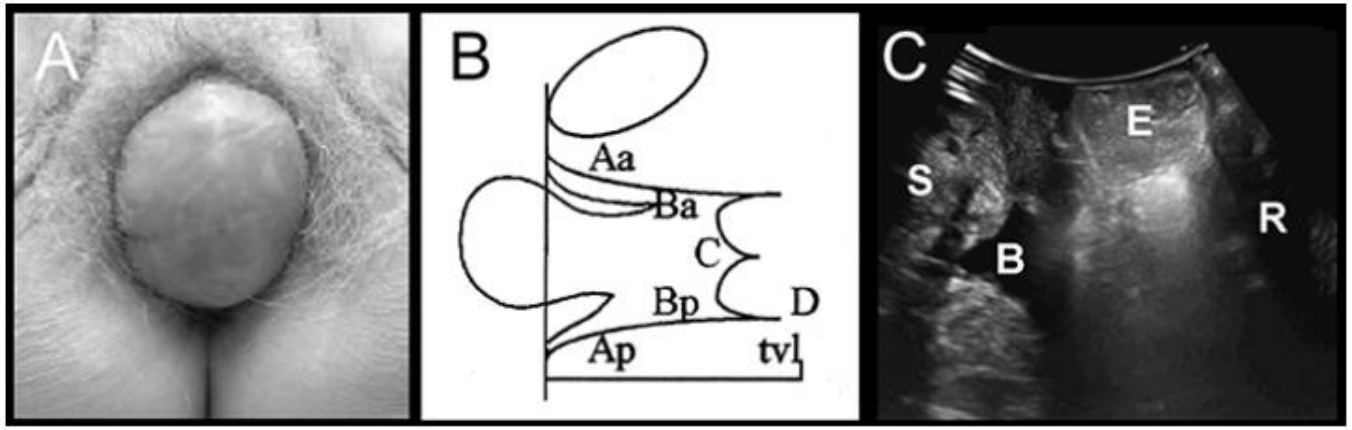


Figure 3. Central compartment prolapse
(A) Vault prolapse on clinical photograph
(B) Representation on POP-Q: Ba = −3, C = +2.5, Bp = −1)
(C) Appearances on imaging: S, symphysis pubis, B; bladder; E, enterocele; R, rectal ampulla

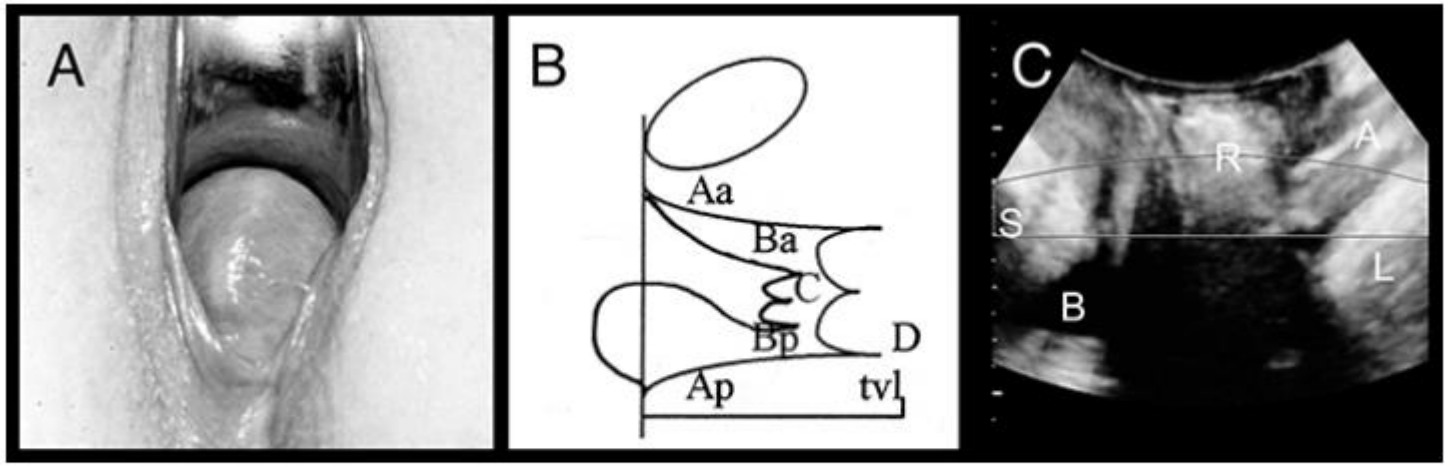


Figure 4. Posterior compartment prolapse
(A) Rectocele on clinical photograph
(B) Representation on POP-Q: Ba = −3; C = −4; Bp = +1
(C) Appearances on imaging: S, symphysis pubis; B, bladder; R, rectocele; A, anal canal; L, levator ani

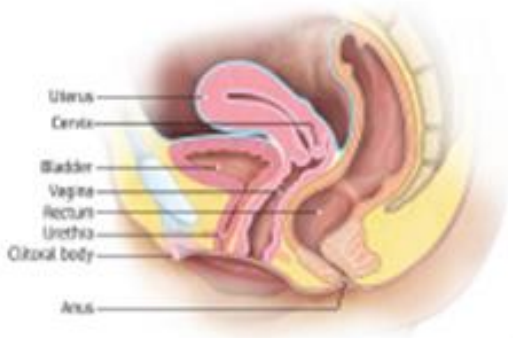
RACGP - Pelvic organ prolapse – a review - https://www.racgp.org.au/afp/2015/july/pelvic-organ-prolapse-a-review

Questions to consider asking your doctor

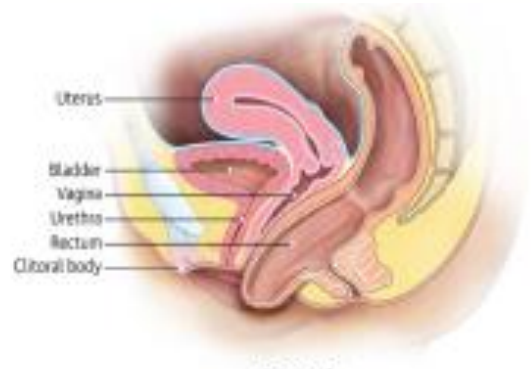
- What are the chances that the prolapse will worsen if I don't do anything?
- What non-surgical options are there to treat my prolapse?
- Will I be able to improve my prolapse by doing pelvic floor exercises and using a pessary?
- What are the benefits and problems of using a pessary?
- What are the surgical options for my prolapse? What are the risks and benefits of these options for me?
- Are you planning to use synthetic mesh in my surgery?
- If you are considering transvaginal mesh, have you obtained the necessary approvals from the hospital where my surgery will be done and the TGA, and what are the risks?
- What are the potential risks of this treatment?
- If transvaginal mesh is proposed, are you credentialed by the hospital where my surgery will be done to use transvaginal mesh to treat prolapse?
- Do you receive payments or other benefits from the manufacture, distribution or implanting of synthetic mesh products?
- If I develop a complication, will you be able to treat me, or will you refer me to another specialist?
- What can I expect to feel after surgery? What specific symptoms should I report to you after the surgery?
- Based on your experience, how long might I have pain after surgery?
- Could I please have a copy of the synthetic mesh product information and the product number? (This may help in any future treatment of your prolapse.)
- Who will perform all, or parts of my surgery?
- Will there be any people from the mesh company in the operating theatre during my procedure?
- If I develop a complication a long time after the surgery, what should I do?

It can be helpful to take a support person with you when you talk to your doctor. You may wish to ask the doctor to explain some answers again.

Types of vaginal prolapse

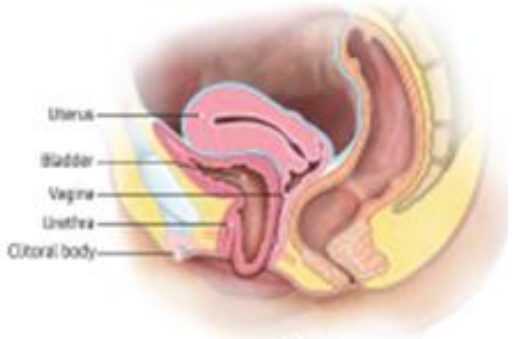


Normal Pelvic Organs



Rectocele

Prolapse of back wall of the vagina (rectocele)



Cystocele

Prolapse of front wall of the vagina (cystocele)

Prolapse of uterus (uterine)

Terms used in this guide

ARTG
Australian Register of Therapeutic Goods

Biological graft
A sheet of absorbable biological material commonly made from cow, pig or human tissues and that is used to reinforce your damaged tissues. Such tissues are highly processed so that only a clean fibrous material remains. Biological grafts are only approved for use in abdominal prolapse repairs, not in transvaginal prolapse repairs.

Colpopexy
An operation to repair prolapse by attachment of the vagina to the abdominal wall or the sacrum with stitches or synthetic mesh. Colpopexy may be performed through an incision in the lower abdomen (laparotomy) or as a keyhole procedure (laparoscopy).

Credentialing
A process used by health service organisations to verify the qualifications and experience of a medical practitioner or other clinician to determine their ability to provide safe, high quality health care services within a specific health care setting and role.

Erosion
Where a mesh implant is partly exposed inside the vagina, bladder or rectum. The synthetic mesh has worked its way outside the vaginal wall and can cause injury to surrounding structures, especially the bladder and bowel.

Extrusion
Where the synthetic mesh used during surgical repair erodes through the skin and tissues and becomes exposed through the vaginal skin.

Ligament
A sheet or band of tough fibrous tissue that holds an organ in place.

Native tissue
Tissue from your own body.

Pelvic floor
The muscles and ligaments at the base of your pelvis that support your womb (uterus), bladder, bladder opening (urethra) and bowel.

Pessary
A removable device that is placed in the vagina to hold prolapsed organs in place.

Synthetic mesh
A man-made, net-like product that is placed in and attached to your pelvis, sometimes with 'anchors' to support your prolapsed organs. Polypropylene is the most common material that mesh is made from. Other terms used for mesh to repair prolapse include tape, ribbon, sling and hammock. Sometimes the term 'mesh kit' is used to refer to packages prepared by manufacturers that include pieces of mesh and anchors.

TGA
Therapeutic Goods Administration. The TGA is responsible for regulating the supply, import, export, manufacturing and advertising of therapeutic goods in Australia.

https://www.safetyandquality.gov.au/sites/default/files/2020-01/treatment_options_for_pelvic_organ_prolapse_pop_-_transvaginal_tv_mesh_-_information_for_consumers_patient_resource.pdf

Consider PELVIC USS (transvaginal preferred) if:

- postmenopausal bleeding.
- pelvic pain.
- pelvic mass.
- bulky or irregular uterus on vaginal examination.
- pelvic mesh complication suspected.

- including bladder USS if co-existing urinary incontinence (check for post void residual)

Prolapse Assessment

Enquire about Previous surgery for prolapse or urinary incontinence

- any complications with previous surgery (by age 80yrs > 10% women will have had prolapse surgery)
- whether pelvic mesh used. If so, determine if the patient is having any complications:
  - Urethral obstruction
  - Urinary Tract Infections
  - Pain
  - Neurologic symptoms
  - Pelvic organ perforation involving bladder, vagina, urethra, bowel
  - Mesh exposure, erosion, and extrusions through vagina, bladder, and urethra
  - Fistulae

Prolapse - Community HealthPathways Brisbane South (SpotOnHealth)

Prolapse Management:

- Weight loss – diet and exercise
- Smoking cessation
- Treat constipation
- Avoid heavy lifting and high impact exercise
- Pelvic floor muscle training (PFMT)
- Bladder & bowel retraining
- Topical oestrogen in post-menopausal women
- Pessaries
- Surgery

Resources:

Joint Report on the Terminology for Female Pelvic Organ Prolapse (POP) - https://onlinelibrary.wiley.com/doi/abs/10.1002/nau.22922

Australian Family Physician – Pelvic Organ Prolapse https://www.racgp.org.au/afp/2015/july/pelvic-organ-prolapse-—- a-review/

RACGP Handbook of Non-Drug Interventions https://www.racgp.org.au/clinical-resources/clinical-guidelines/handi

Pelvic floor muscle training: pelvic organ prolapse

Conditions

Pelvic organ **prolapse** occurs to some degree in 50% of parous women

Pelvic floor muscle training: pelvic organ prolapse

A-Z interventions and conditions

Pelvic organ **prolapse** occurs to some degree in 50% of parous women

Pelvic floor muscle training for women

Patient Resources

Your doctor has recommended pelvic floor muscle training

Pelvic floor muscle training for women

A-Z interventions and conditions

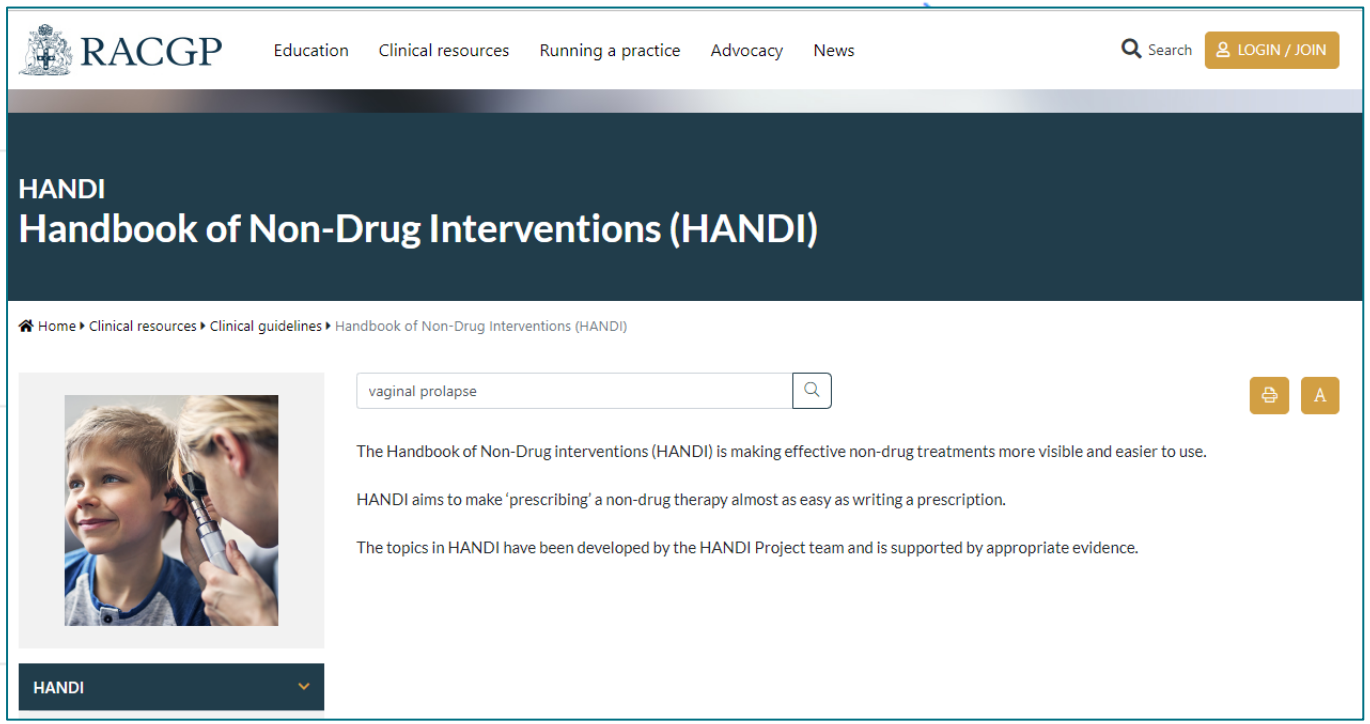
Your doctor has recommended pelvic floor muscle training

Pelvic floor muscle training: urinary incontinence

Conditions

Estimates suggest that over 4 million Australians over 15 years of age are living with some degree of urinary incontinence (around 37% of women and 13% of men)

RACGP - Handbook of Non-Drug Interventions (HANDI)



[Pelvic Floor First website: https://www.pelvicfloorfirst.org.au/pages/pelvic-floor-muscle-exercises-for-women.html](https://www.pelvicfloorfirst.org.au/pages/pelvic-floor-muscle-exercises-for-women.html)

Women

Pelvic Floor Exercise

The first step in performing pelvic floor muscle exercises is to identify the correct muscles.

How can I find my pelvic floor muscles?

Method 1 – Stopping the flow

There are several ways which may help you to correctly identify the different parts of your pelvic floor muscles. One way is to try to stop or slow the flow of urine midway through emptying the bladder. Stopping the flow of urine repeatedly on the toilet is not an exercise, but a way of identifying your pelvic floor muscles. This should only be done to identify which muscles are needed for bladder control.

If you can, stop the flow of urine over the toilet for a second or two, then relax and finish emptying without straining. This 'stop-test' may help you identify the muscles around the front passage which control the flow of urine. It is not recommended as a regular exercise.

Method 2 – Visualisation

Another method to identify your pelvic floor muscles is to imagine stopping the flow of urine and holding in flatus (wind) at the same time. This can be done lying down, sitting or standing with legs about shoulder width apart.

- Relax the muscles of your thighs, bottom and abdomen (tummy).
- Squeeze in the muscles around the front passage as if trying to stop the flow of urine.
- Squeeze in the muscles around the vagina and suck upwards inside the pelvic.
- Squeeze in the muscles around the back passage as if trying to stop passing wind.
- The muscles around the front and back passages should squeeze up and inside the pelvis.
- Women who are familiar with using tampons can imagine squeezing in the vagina as if squeezing a tampon up higher in the vagina.
- Identify the muscles that contract when you do all these things together. Then relax and loosen them.

Getting the technique right

This is the most important part of the pelvic floor muscle exercises as there is no point doing them if you are not doing them correctly.

Imagine letting go like you would to pass urine or to pass wind. Let your tummy muscles hang loose too. See if you can squeeze in and hold the muscles inside the pelvis while you breathe. Nothing above the belly button should tighten or tense. Some tensing and tightening of the lower part of the tummy wall will happen. This is not a problem, as this part of the tummy works together with the pelvic floor muscles.

Try tightening your muscles really gently to feel just the pelvic floor muscles lifting and squeezing in. If you cannot feel your muscles contracting, change your position and try again. For example, if you cannot feel your muscles contracting in a seated position, try lying down or standing up instead.

After a contraction it is important to relax the muscles. This will allow your muscles to recover from the previous contraction and prepare for the next contraction.

It is common to try too hard and have too many outside muscles tighten. This is an informal exercise and correct technique is vital. Doing pelvic floor muscle exercises the wrong way can be bad for you, so please see a health professional if you cannot feel your muscles hold or relax.

Exercising your pelvic floor muscles

Once you have mastered the art of contracting your pelvic floor muscles correctly, you can try holding the inward squeeze for longer (up to 10 seconds) before relaxing. Make sure you can breathe easily while you squeeze.

If you can do this exercise, repeat it up to 10 times, but only as long as you can do it with perfect technique while breathing quietly and keeping everything above the belly button relaxed. This can be done more often during the day to improve control.

Useful resources for exercising pelvic floor muscles:

- Pelvic Floor Muscle Training for Women
- Pelvic Floor Muscle Exercises for Women (for Aboriginal and Torres Strait Islanders)
- Pelvic Floor Muscle Exercises (Easy English)

When to seek professional help

Seek professional help when you have bladder or bowel control problems with symptoms such as:

- needing to urgently or frequently go to the toilet to pass urine or bowel motions
- accidental leakage of urine, bowel motions or wind
- difficulty emptying your bladder or bowel
- vaginal heaviness or a bulge
- pain in the bladder, bowel or in your back near the pelvic floor area when exercising the pelvic floor or during intercourse

These problems may not necessarily be linked to weak pelvic floor muscles and should be properly assessed.

Like all exercises, pelvic floor exercises are most effective when individually tailored and monitored. The exercises described are only a guide and may not help if done incorrectly or if the training is inappropriate.

Incontinence can have many causes and should be individually assessed before starting a pelvic floor muscle training program. Tightening or strengthening pelvic floor muscles may not be the most appropriate treatment so speak to a health professional if you have persistent problems with your bladder or bowel. Visit the Resources page for more information.

Health professionals

Continence and women's health or pelvic floor physiotherapists specialise in pelvic floor muscle exercises. They can assess your pelvic floor function and tailor an exercise program to meet your specific needs. They can also prescribe other treatment options such as biofeedback and discuss relevant lifestyle factors with you.

For a list of continence and women's health or pelvic floor physiotherapists, search the Continence Foundation of Australia's service provider directory or call the National Continence Helpline on 1800 33 00 66.

You may also like to see:

- Video: Learn how to do pelvic floor muscle exercises

Care Pathway for the Management of Pelvic Organ Prolapse (POP)

SPECIALIST MANAGEMENT

This may include care by gynaecologists, urogynaecologists, urologists and colorectal surgeons with a special interest in pelvic floor

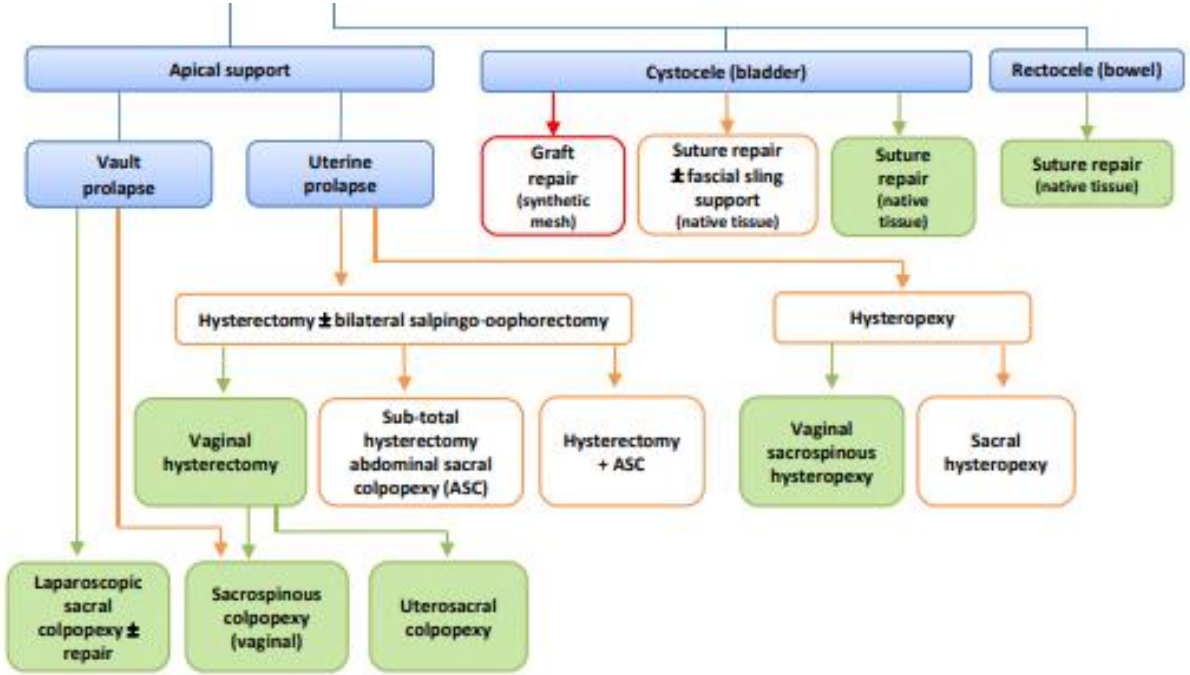
- **No treatment**
- **Non-surgical treatments**
- **Patient assessed as requiring operative management**

POP Surgical Pathway

POP Surgery

Consider:
- Bladder function
- Bowel function
- Risk of recurrent prolapse
- Bowel symptoms that warrant colonoscopy

- **Reconstructive surgery**
  Involves repair of apical (upper prolapse), anterior (bladder) and/or posterior (bowel)
- **Obliterative surgery: usually performed with the elderly, medically compromised and not sexually active**



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

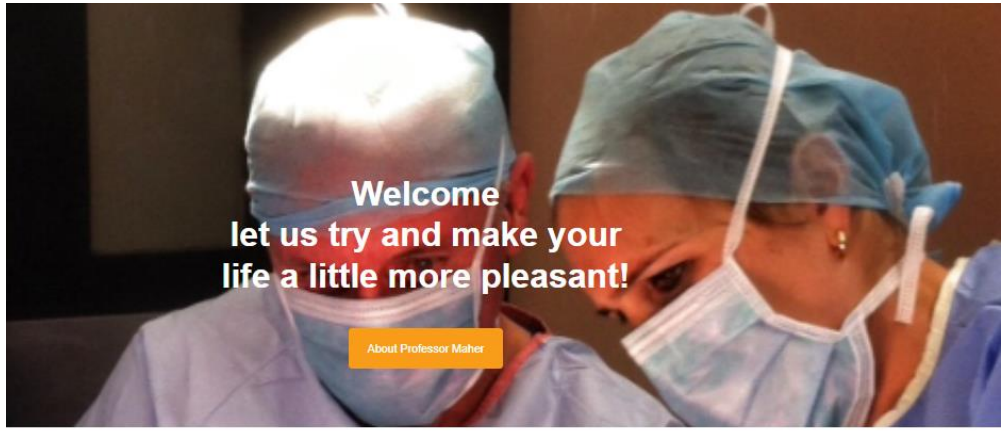
AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

D17-21886

4/07/2018

Surgical Management of Prolapse:

- About 50% of women who have had children have prolapse BUT only 12-20% women undergo prolapse surgery
- Pelvic floor exercises can help with early prolapse
- Vaginal ring pessaries can help BUT only about 10% continue pessary use after 5 years
- Treatment of prolapse may expose pre-existing weaknesses of the urinary continence mechanism. Continence may be maintained if the urethra is kinked by cystocele descent or compressed by a rectocele or enterocele. Prolapse reduction may then cause incontinence, which may generate more bother than the original prolapse and also require surgery.



Welcome let us try and make your life a little more pleasant!

Pathway for the surgical treatment of pelvic organ prolapse [ICI 2022 Surgical Pathway POP - (urogynaecology.com.au)]

An interactive version (2017) can also be found [HERE]

What are my treatment options?

2 Non-surgical treatment options

You may be able to improve some symptoms without surgery with lifestyle changes, pelvic floor exercises, pessaries, and topical oestrogen cream. These treatment options are safe, and either alone, or in combination, may give you good results. However, these options may not work for everyone and you may still have symptoms that affect your quality of life. More studies are needed to understand how beneficial pelvic floor exercises, lifestyle changes and pessaries are in treating prolapse.[2]

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists recommends that you and your doctor discuss non-surgical treatment options.

Lifestyle changes

Non-surgical options that you should consider are reducing weight, avoiding heavy lifting, avoiding constipation and chronic coughing, stopping smoking and doing low impact exercises. Each of these options can help lessen your awareness of prolapse and contribute to overall good health.

These changes need consistent effort, over the long term, as it takes time for lifestyle changes to work. Support from a health professional such as a dietitian or your general practitioner may be helpful, as well as support from family and friends to assist in making these lifestyle changes.

Pelvic floor exercises

Pelvic floor exercises are intended to strengthen the pelvic floor, over time, through actively tightening and lifting the muscles at regular intervals. It is important to involve a health professional specialising in the pelvic floor, such as a physiotherapist with a special interest in pelvic floor dysfunction or continence nurse, to give instruction and assist in improving the outcomes of these exercises.

These exercises can reduce symptoms, or the need for surgery, and help decrease the awareness of prolapse and reduce the need for surgery. They need to be done correctly and consistently over time; these exercises are not a quick fix. If muscles are very weak, there are other additional treatments that may help; a physiotherapist with a special interest in pelvic floor dysfunction may suggest biofeedback or electrical stimulation.

An internal examination and some specialised tests may also need to be performed to assess whether you are doing the exercises correctly and whether they are helping improve your pelvic floor strength.

Information about pelvic floor exercises, continence and women's health or physiotherapists with a special interest in pelvic floor dysfunction is available from the Australian Physiotherapy Association ***www.physiotherapy.asn.au/APAWCM/Physio_and_You/Pelvic_Floor.aspx*** or the National Continence Helpline on 1800 33 00 66 or the Continence Foundation of Australia at: ***www.continence.org.au/pages/pelvic-floor-women.html***.

Vaginal pessary

Your doctor or a physiotherapist with a special interest in pelvic floor dysfunction can insert a removable device, called a pessary. This is inserted into your vagina to support the walls of your vagina and/or uterus. Pessaries are made from materials such as vinyl, silicone or latex.

More studies are needed to understand how beneficial pelvic floor exercises, lifestyle changes and pessaries are in treating prolapse. However, it is safe to use pessaries, both short- and long-term. When insertion is successful there may be improvement in prolapse symptoms and in bladder, bowel and sexual function.

You may need an internal examination and try a few types and sizes of pessaries to find what works for you. The material that the pessary is made of may cause a reaction in some women, for example, if you have a latex allergy. Some types of pessaries are shown on page 4.

Topical oestrogen

Oestrogen cream can be applied to reduce vaginal dryness and improve tissue quality of a prolapsed vaginal wall. Where urinary infection has been a factor, this may be helpful.

[2] Genital Prolapse. Fact Sheet. 2011. http://womhealth.org.au/sites/womhealth/files/public/documents/Genital%20prolapse.pdf.

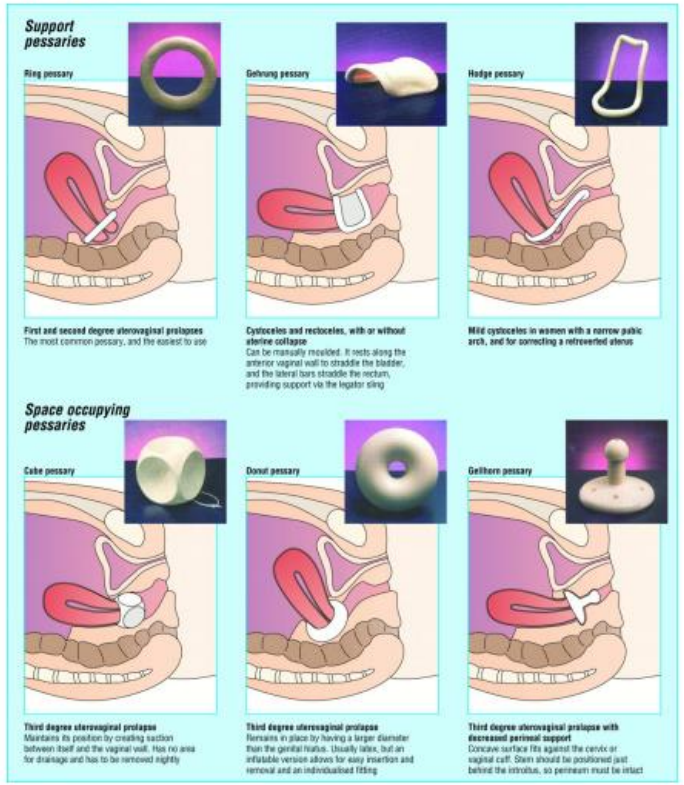
Understanding the risks and benefits of treatment

You have a right to be informed about services, treatment, options and costs in a clear and open way and be included in decisions and choices about your care.

Before deciding about your health care, it is important that you fully understand the risks and benefits of any medical test, treatment and procedure recommended by your doctor.

Asking questions about your testing and treatment options will help you and your doctor or other health care provider make better decisions together. These discussions also support the consent process.

Types of pessaries



Source: Reproduced from [BMJ, Management of genital prolapse, Ranee Thakar, Stuart Stanton BMJ 2002;324:12 www.bmj.com/content/324/7348/1258.1] with permission from BMJ Publishing Group Ltd

3 Surgical treatment options

If non-surgical treatments do not work for you and your symptoms are severe and disrupt your life, you may consider surgery. Surgery to repair the prolapse can involve use of either your own tissue (native tissue) or a biological graft (human or animal) or polypropylene mesh.

The repairs may be made by insertion of mesh through your abdomen or through your vagina using either dissolvable or permanent stitches. Biological grafts are only approved for use in abdominal prolapse repairs, not in transvaginal prolapse repairs.

You may find it helpful to take a family member or friend to support you in discussing your options and the next steps with your doctor. You may also consider getting more than one opinion on surgical treatments if you feel this would be of assistance.

There is a risk that surgical procedures may not fix the prolapse. The risk of recurrent prolapse is higher following native tissue and biological graft repairs compared to polypropylene mesh repairs.

Some surgical options have involved the use of transvaginal mesh. Many women have had successful repairs of their prolapse using transvaginal mesh, however many have also experienced serious complications which are debilitating and affect their everyday lives. The number of women in Australia who have had transvaginal mesh implanted is not accurately known.

Mesh may also be inserted through the abdomen, which has been associated with fewer complications than transvaginal mesh, including lower re-operation rate and improved outcomes compared with both native tissue, biological graft and transvaginal mesh repairs. Mesh for use in this way is still included on the ARTG.

Complications of transvaginal mesh reported by some women include: mesh migration, extrusion or erosion resulting in lacerations of vessels and organs, including the bladder and vagina; continual chronic pain; painful sexual intercourse; and nerve damage. These complications can be debilitating and life-altering. The TGA website includes a comprehensive list of potential complications ***www.tga.gov.au/alert/urogynaecological-surgical-mesh-complications***.

Native tissue repair

This type of procedure involves reinforcing your damaged tissue by attaching them to your ligaments, with a graft of tissue from another part of your body (such as the lower abdomen) or with stitches. There are several types of native tissue repair operations, depending on the position of the prolapse. These include:

- anterior vaginal repair
- posterior vaginal repair
- vaginal colpopexy.

Information about the various types of repair surgery can be found on the Urogynaecological Society of Australasia website at: ***www.ugsa.com.au/home-2/patient-resources/***.

Your doctor should explain the approach that is best for the type of prolapse you have, considering your general health and fitness for surgery.

Native tissue repair has a higher risk of recurrent prolapse compared with synthetic mesh and, as for all types of prolapse repair, there is a risk of development of pelvic pain in the short and long term. If you do develop pelvic pain, it can be difficult to treat.

Synthetic mesh repair

Synthetic mesh is a man-made, net-like product that may be placed in, and attached to, your pelvis; sometimes with 'anchors' to support your prolapsed organs. Mesh and the anchors are most commonly made from polypropylene.

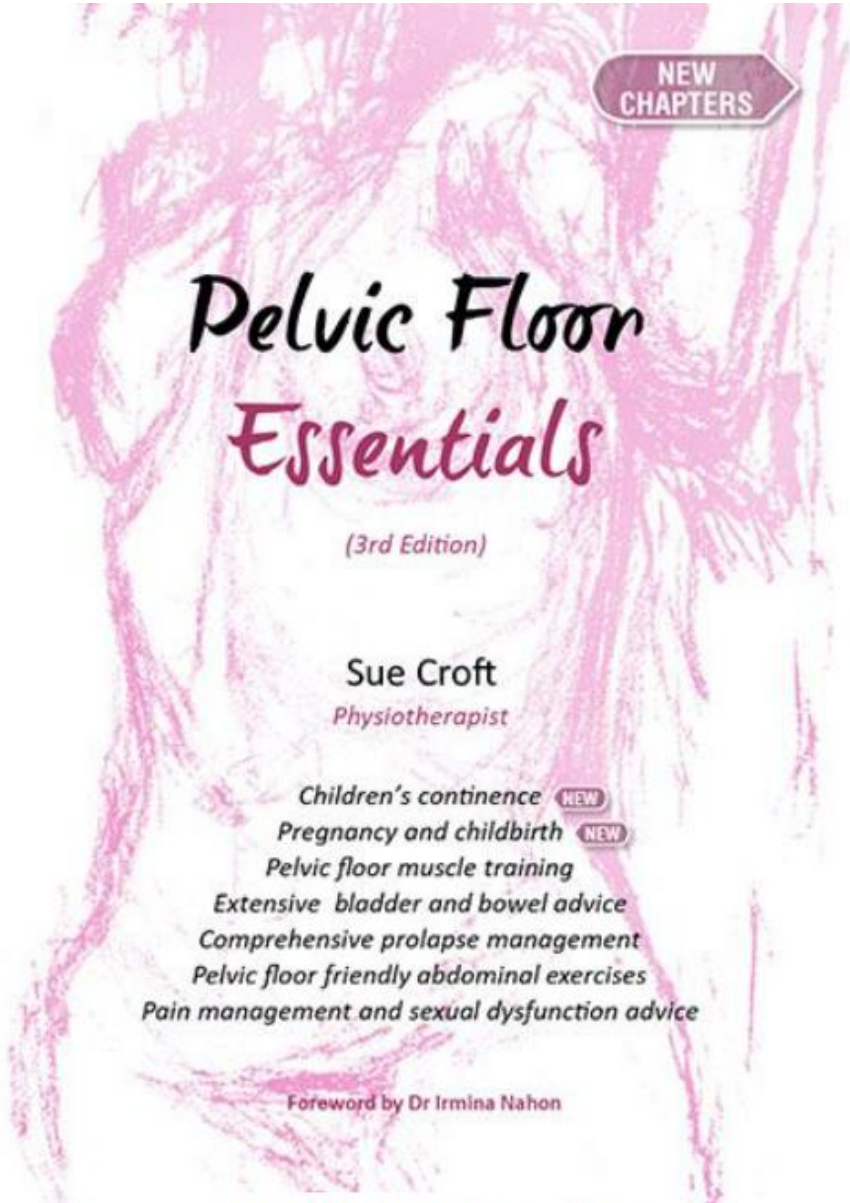
The mesh is intended to remain in the body permanently. If complications occur, additional surgery may be required. Complications may not completely resolve, even if the mesh is removed. Complete removal of the mesh is not always possible and multiple surgeries might be required.

Information about the various types of repair surgery using mesh inserted through the abdomen can be found on the Urogynaecological Society of Australasia website at: ***www.ugsa.com.au/home-2/patient-resources/.***

If your doctor suggests the use of mesh in this way you should discuss the risks and benefits of doing so.

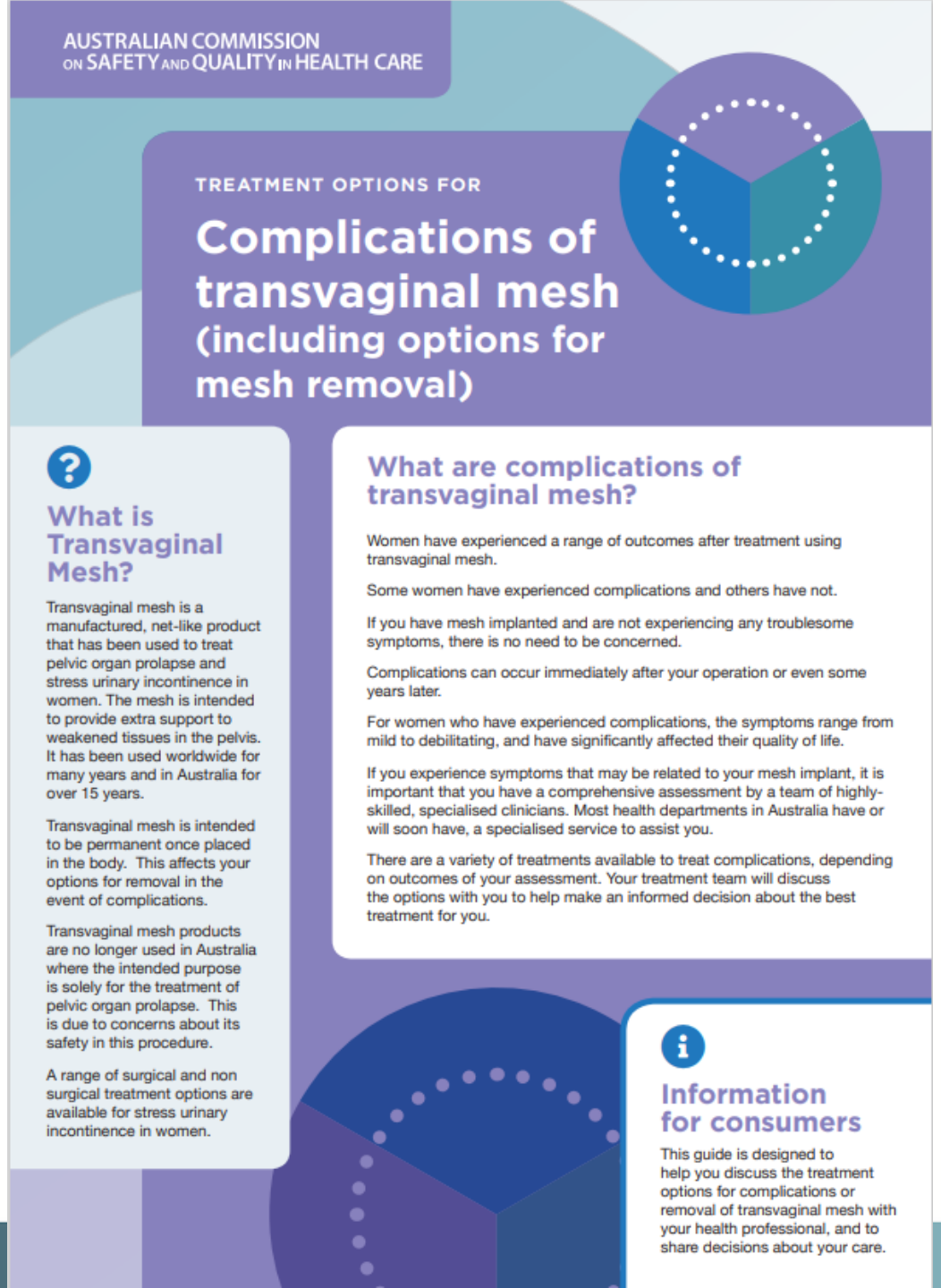
"This is a comprehensive guide for women of all ages regarding pelvic floor function and advice. The publication of this 5th Edition is testament to the popularity of the book. I do advise women of all ages to read Sue's book 'Pelvic Floor Recovery' to improve their pelvic floor function and quality 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."

PROF JUDITH GOH AO
UROGYNAECOLOGIST



Pelvic Floor Essentials by Sue Croft*

https://www.safetyandquality.gov.au/sites/default/files/migrated/Treatment-Options-Complications-Consumer-Info.pdf - TREATMENT OPTIONS FOR Complications of transvaginal mesh (including options for mesh removal)



AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

TREATMENT OPTIONS FOR

Complications of transvaginal mesh (including options for mesh removal)

What is Transvaginal Mesh?

Transvaginal mesh is a manufactured, net-like product that has been used to treat pelvic organ prolapse and stress urinary incontinence in women. The mesh is intended to provide extra support to weakened tissues in the pelvis. It has been used worldwide for many years and in Australia for over 15 years.

Transvaginal mesh is intended to be permanent once placed in the body. This affects your options for removal in the event of complications.

Transvaginal mesh products are no longer used in Australia where the intended purpose is solely for the treatment of pelvic organ prolapse. This is due to concerns about its safety in this procedure.

A range of surgical and non surgical treatment options are available for stress urinary incontinence in women.

What are complications of transvaginal mesh?

Women have experienced a range of outcomes after treatment using transvaginal mesh.

Some women have experienced complications and others have not.

If you have mesh implanted and are not experiencing any troublesome symptoms, there is no need to be concerned.

Complications can occur immediately after your operation or even some years later.

For women who have experienced complications, the symptoms range from mild to debilitating, and have significantly affected their quality of life.

If you experience symptoms that may be related to your mesh implant, it is important that you have a comprehensive assessment by a team of highly-skilled, specialised clinicians. Most health departments in Australia have or will soon have, a specialised service to assist you.

There are a variety of treatments available to treat complications, depending on outcomes of your assessment. Your treatment team will discuss the options with you to help make an informed decision about the best treatment for you.

Information for consumers

This guide is designed to help you discuss the treatment options for complications or removal of transvaginal mesh with your health professional, and to share decisions about your care.

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

Urinary Incontinence in Women

Dr Sanja Savic
Staff Specialist Obstetrics and Gynaecology
Logan Hospital

ICARE² values

INTEGRITY COMPASSION ACCOUNTABILITY RESPECT ENGAGEMENT EXCELLENCE

Queensland Government

RACGP Red Book - Urinary incontinence

“Of those sitting in a GP waiting room, 65% of women and 30% of men report some type of urinary incontinence, yet only 31% of these people report having sought help from a health professional.[1]

Primary care professionals are in a position to take a more proactive approach to incontinence treatment by asking about urinary symptoms in at-risk groups during routine appointments. There remains considerable health decrement due to urinary incontinence in those not receiving help in a population readily accessible to primary care services.[2]”

WE NEED TO ASK MORE OFTEN!!

1. Byles J, Chiarelli P, Hacker A, Bruin C. Help seeking for urinary incontinence: A survey of those attending GP waiting rooms. Aust Continence J 2003;9(1):8–15.
2. Shawa C, Gupta RD, Bushnell DM, Passassa R, Abrams P, Wagg A. The extent and severity of urinary incontinence amongst women in UK GP waiting rooms. Fam Pract 2006;23(5):497–506

https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/guidelines-for-preventive-activities-in-general-pr/urinary-incontinence

Appendix 13A. The 3 Incontinence Questions (3IQ)

1. During the last three months, have you leaked urine (even a small amount)?

   ☐ Yes ☐ No → Questionnaire completed.

2. During the last three months, did you leak urine (check all that apply):
   - a. ☐ When you were performing some physical activity, such as coughing, sneezing, lifting, or exercise?
   - b. ☐ When you had the urge or feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?
   - c. ☐ Without physical activity and without a sense of urgency?

3. During the last three months, did you leak urine most often (check only one):
   - a. ☐ When you are performing some physical activities, such as coughing, sneezing, lifting, or exercise?
   - b. ☐ When you had the urge or feeling that you needed to empty your bladder, but you could not get to the toilet fast enough?
   - c. ☐ Without physical activity or a sense of urgency?
   - d. ☐ About equally as often with physical activities as with a sense of urgency?

Definitions of the type of urinary incontinence are based on responses to Question 3

Response to question 3	Type of incontinence
a. Most often with physical activity	Stress only or stress predominant
b. Most often with the urge to empty the bladder	Urge only or urge predominant
c. Without physical activity or sense of urgency	Other cause only or other cause predominant
d. About equally with physical activity and sense of urgency	Mixed

Reproduced with permission from Brown JS, Bradley CS, Subak LL, et al. The sensitivity and specificity of a simple test to distinguish between urge and stress incontinence. Ann Intern Med 2006;144(10):715–23.

Table 13.2. Urinary incontinence: Preventive interventions

Intervention	Technique	References
Case finding	Probing questions such as 'Other people with … [state conditions of higher risk here] have had problems with their waterworks [bladder control] …' Simple patient survey assessment tools have been shown to be valid and reliable (A)	6
Assessment	Patients with urinary incontinence should be assessed to determine the diagnostic category as well as underlying aetiology. This can usually be determined on the basis of history, physical examination, and urinary dipstick and culture, if indicated. A post-void residual may be required in the assessment of possible retention and/or overflow There are four common types of incontinence: 1. **Stress incontinence** is the leaking of urine that may occur during exercise, coughing, sneezing, laughing, walking, lifting or playing sport. This is more common in women, although it also occurs in men, especially after prostate surgery. Pregnancy, childbirth and menopause are the main contributors 2. **Urge incontinence** is a sudden and strong need to urinate. It is often associated with frequency and nocturia, and is often due to having an over-active or unstable bladder, neurological condition, constipation, enlarged prostate or history of poor bladder habits 3. **Mixed incontinence** is a combination of stress and urge incontinence, and is most common in older women 4. **Overflow incontinence** as a result of bladder outflow obstruction or injury. Its symptoms may be confused with stress incontinence Because treatments differ, urge incontinence should be distinguished from stress incontinence (A) To make this distinction, the International Continence Society guidelines recommend an extensive evaluation that is too time-consuming for primary care practice However, the 3 Incontinence Questions (3IQ) questionnaire is a simple, quick, and non-invasive test with acceptable accuracy for classifying urge and stress incontinence, and may be appropriate for use in primary care settings (A). The questionnaire is provided in Appendix 13A	7 8, 9

https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/guidelines-for-preventive-activities-in-general-pr/urinary-incontinence

Urinary incontinence: Identifying risk

Table 13.1. Urinary incontinence: Identifying risk

Who is at higher risk of urinary incontinence?	What should be done?	How often?	References
Average risk:	There is no evidence to support screening (IV)	N/A	
Higher risk: • Prenatal and postnatal women • Women who have had children • Women who are overweight • Women reporting constipation • People with respiratory conditions, diabetes stroke, heart conditions, recent surgery, neurological disorders • Frail elderly people or long-term care residents	Case finding (IV, B) Ask about the occurrence of urinary incontinence In residential aged care facilities, residents are automatically assessed	Every 12 months	2

https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/guidelines-for-preventive-activities-in-general-pr/urinary-incontinence

Stress Urinary Incontinence - Definition

- **Symptom** of stress urinary incontinence:
  - patient's or caregiver's statement of involuntary loss of urine during physical exertion.
- **Sign** of stress urinary incontinence:
  - objective demonstration of loss of urine synchronous with physical exertion.
- **Condition** of genuine (urodynamic) stress incontinence:
  - is the involuntary loss of urine occurring as a result of a rise in intra-abdominal pressure, in the absence of a detrusor contraction (modified from the International Continence Society definition).

Severity of Stress Incontinence

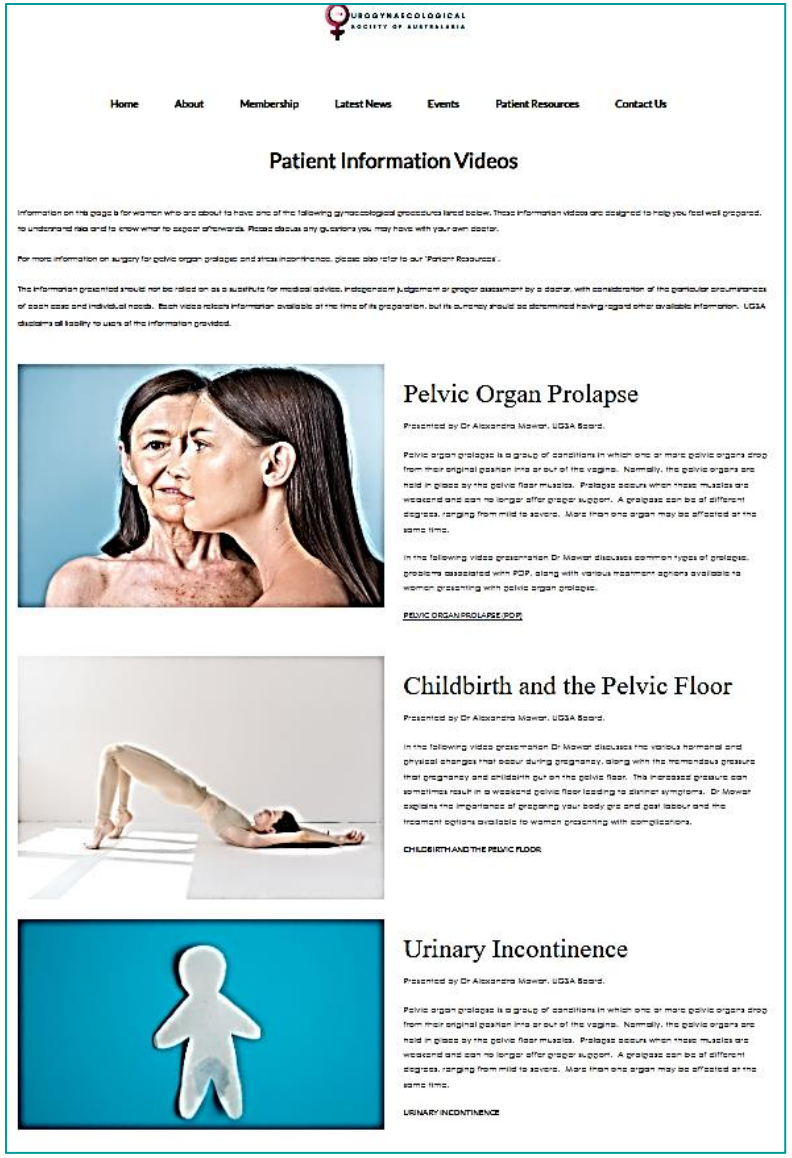
- How bothersome is the incontinence?
- How often is there leakage?
- When does it occur?
  - Mild – leaks on dancing, trampolining, or sports related activity.
  - Moderate – leaks on coughing and sneezing.
  - Severe – leaks on walking downhill or rising from a low chair.
- Has the patient completed her family?

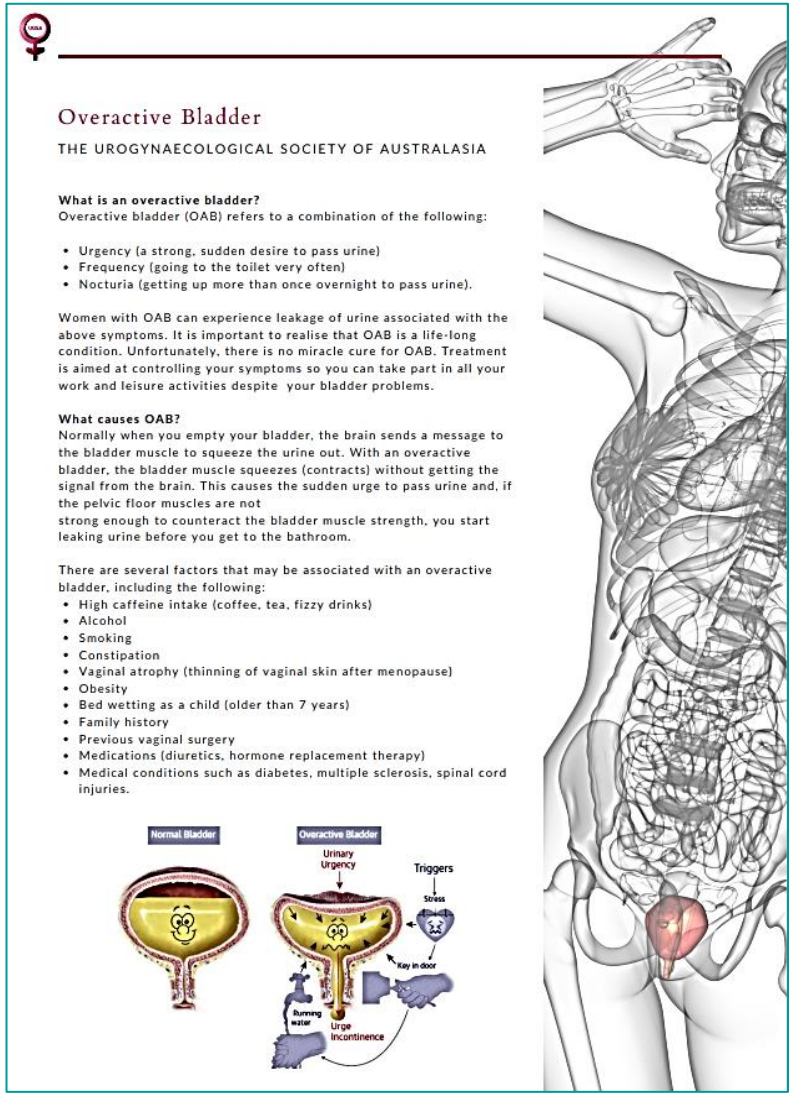
Urinary Incontinence in Women - Community HealthPathways Brisbane South (SpotOnHealth)

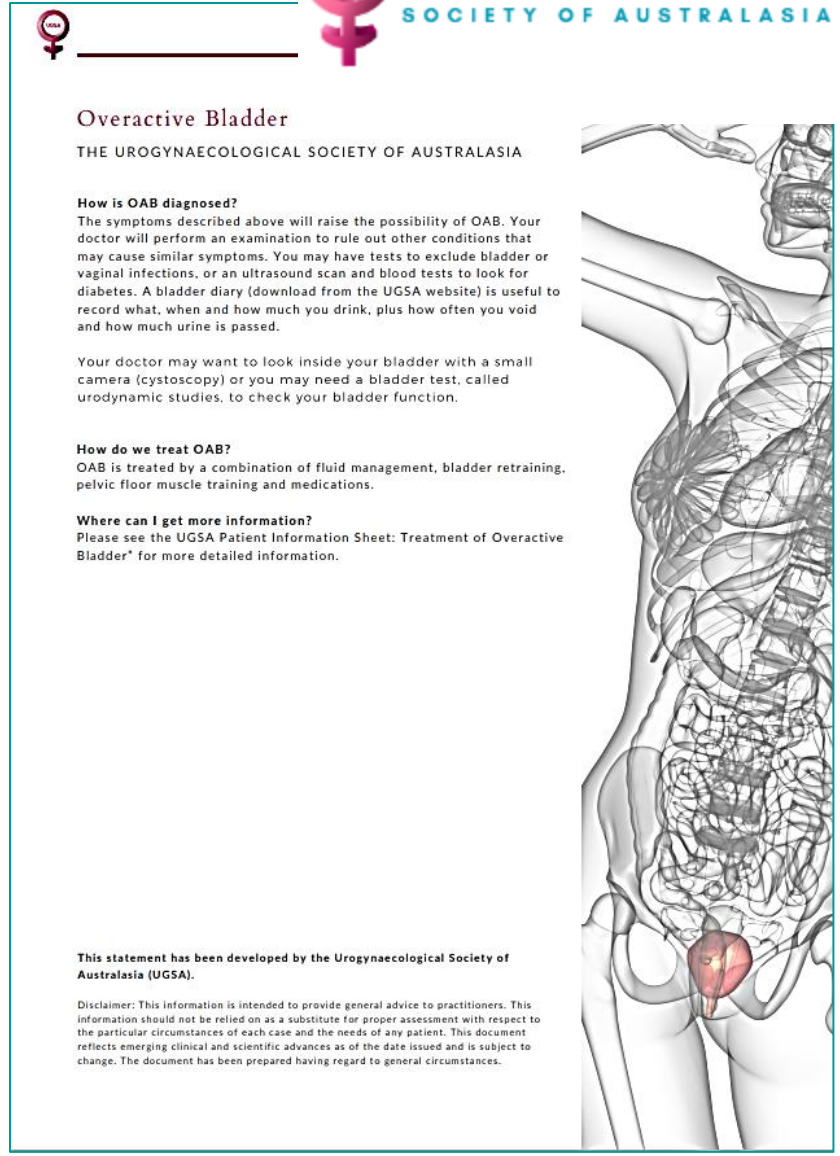
URGE Urinary Incontinence: Definitions

- **Frequency** : patient voids eight or more times in 24 hours.
- **Nocturia** : patient wakes from sleep in order to pass urine.
- **Urgency**: patient feels a strong need to pass urine for fear of leakage.
- **Urge urinary incontinence**: patient has involuntary loss of urine associated with a feeling of urgency (modified from the International Continence Society definition).
- **Nocturnal enuresis** denotes loss of urine during sleep.
- **Overactive Bladder** describes symptoms suggestive of detrusor overactivity (detrusor instability) and is defined as urgency and/or urge incontinence, usually occurring with urinary frequency, in the absence of local pathological or metabolic factors (such as urinary tract infection or polyuria with diabetes).

Weber, A., Abrams, P., Brubaker, L. *et al.* The Standardization of Terminology for Researchers in Female Pelvic Floor Disorders . *Int Urogynecol J* **12**, 178–186 (2001) DOI - https://doi.org/10.1007/PL00004033







UroGynaecological Society of Australasia – Patient Information
https://www.ugsa.com.au/home-2/patient-resources/

More Definitions

- Mixed Stress and Urge Incontinence
- Overflow Incontinence:

  Involuntary loss of urine associated with chronic urinary retention. Leakage usually intermittent but may be continual; should be strongly considered if the patient has nocturnal enuresis.

  Consider if large residual volumes (e.g., > 500mL) of urine & spillage resulting in incontinence.

  If present, consider:

  - bladder outlet obstruction e.g., urethral stricture.
  - neurological causes (e.g., multiple sclerosis, stroke, Parkinson disease).
  - medications causing a hypocontractile bladder
- Ask re associated faecal incontinence
- Consider cauda equine (reduced sensation in saddle area, sexual dysfunction and back and leg pain, and lower limb motor or sensory changes) and UT Malignancy

Consider other contributors:

- Medical conditions – COPD, screen for diabetes, neurogenic bladder (e.g., MS, Parkinson’s disease, spinal cord injury, stroke, previous pelvic surgery)
- Medications
- Caffeine, alcohol, carbonated beverage avoidance
- Smoking cessation
- Weight change – diet and exercise

Urinary Incontinence Assessment

- Abdominal examination – bladder or renal tenderness or masses
- Pelvic examination including vaginal and perineal assessment
- Assess pelvic floor muscle function, coordination and tone

- MSU M/C/S
- USS kidneys, ureters, bladder, including post void residual
- ELFTs

- Quantify leakage (e.g., size and number of pads per day, changes of clothes/day)
- Bladder diary
- Bowel diary

Urinary Incontinence Assessment

- Physiotherapy and/or continence nurse management e.g. pelvic floor muscle exercises and bladder training
- Consider anticholinergics if:
  - low residuals on bladder scan
  - no suspicion of a sinister cause
  - not hypersensitive to the drug
  - no history of acute angle glaucoma

- ? In whom would urodynamics be helpful
- 18/12 public wait list for same

Urodynamic study

Assessment of bladder and urethral function during filling and emptying bladder

FLOW

- RATE - average and maximal flow
- TIME – normal or prolonged flow
- PATTERN – smooth or intermittent pattern

VOLUME

- FIRST DESIRE TO VOID
- MAXIMUM DESIRE TO VOID (bladder capacity)
- POSTVOID RESIDUE

PRESSURE

- ABDOMINAL PRESSURE
- BLADDER (VESICAL) PRESSURE
- MAXIMAL URETHRAL CLOSURE PRESSURE
- DETRUSOR PRESSURE AT MAXIMUM FLOW

URODYNAMIC STRESS INCONTINENCE

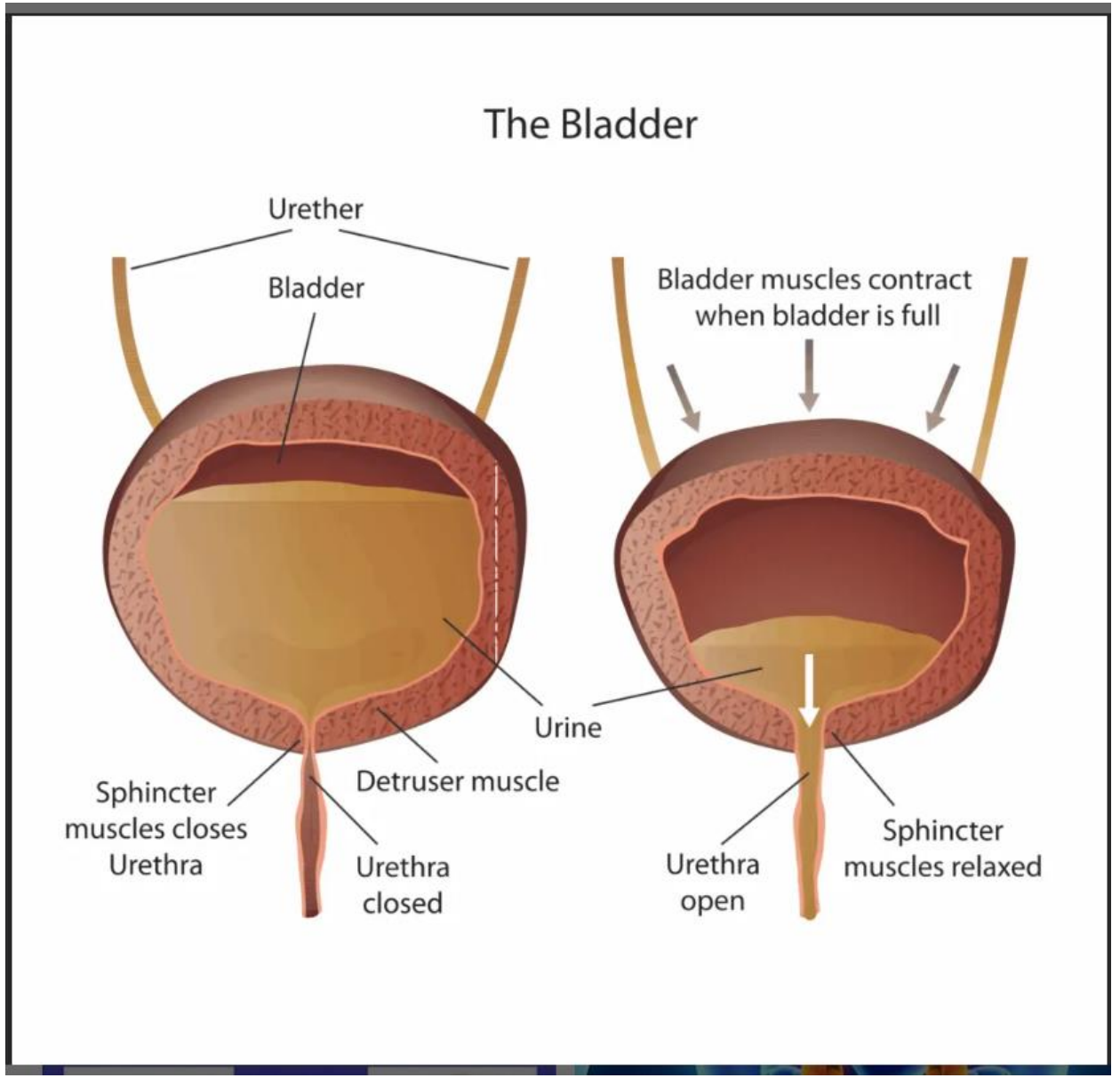
- urethral leakage with increased abdominal pressure

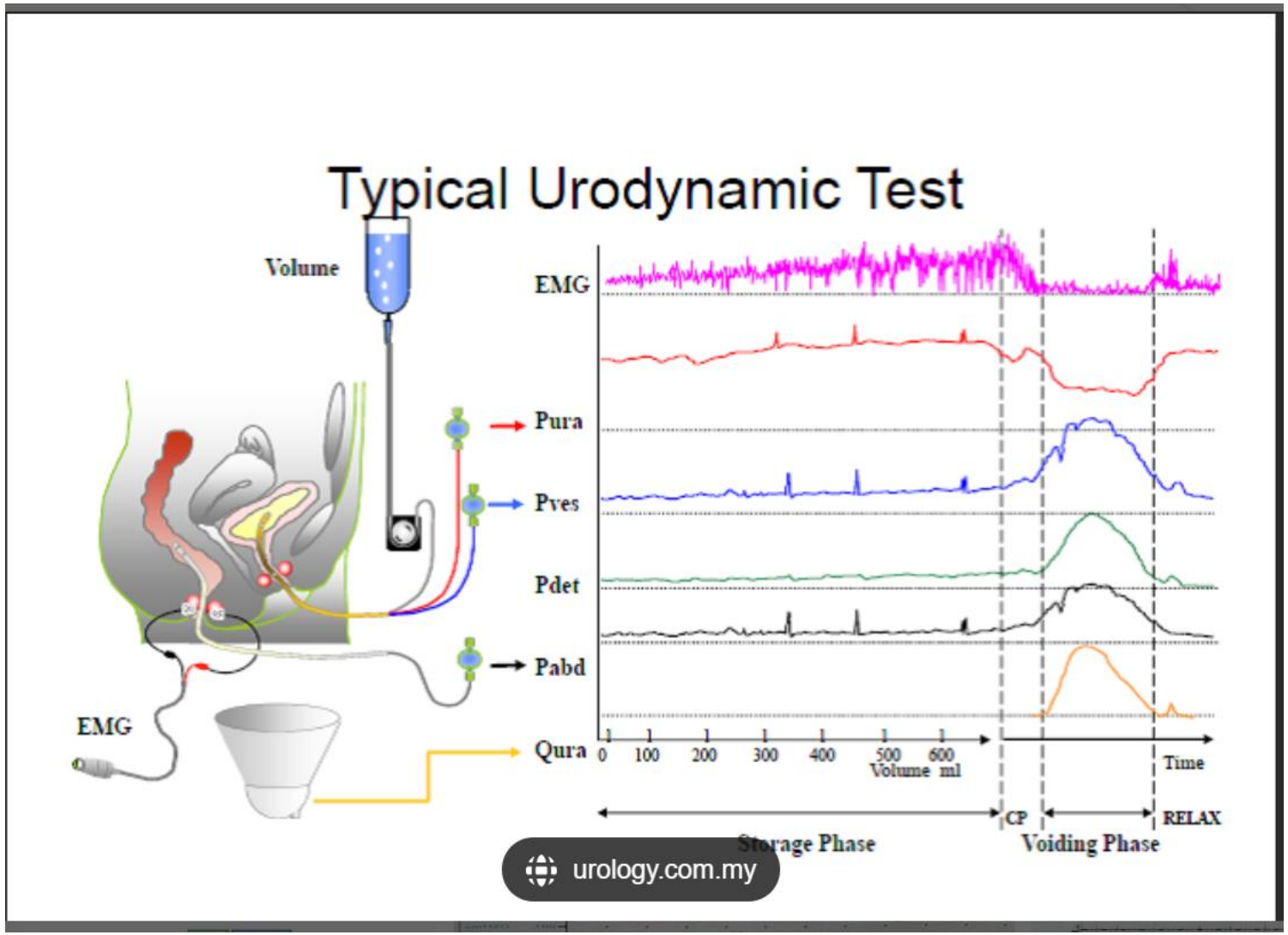
DETRUSOR OVERACTIVITY

- involuntary contraction of detrusor muscle with or without leakage

INTRINSIC SPHINCTER DYSFUNCTION

POOR DETRUSOR CONTRACTILITY V OBSTRUCTION


The Bladder
Urether
Bladder
Bladder muscles contract when bladder is full
Urine
Detruser muscle
Sphincter muscles closes Urethra
Urethra closed
Urethra open
Sphincter muscles relaxed


Typical Urodynamic Test
Volume
EMG
Pura
Pves
Pdet
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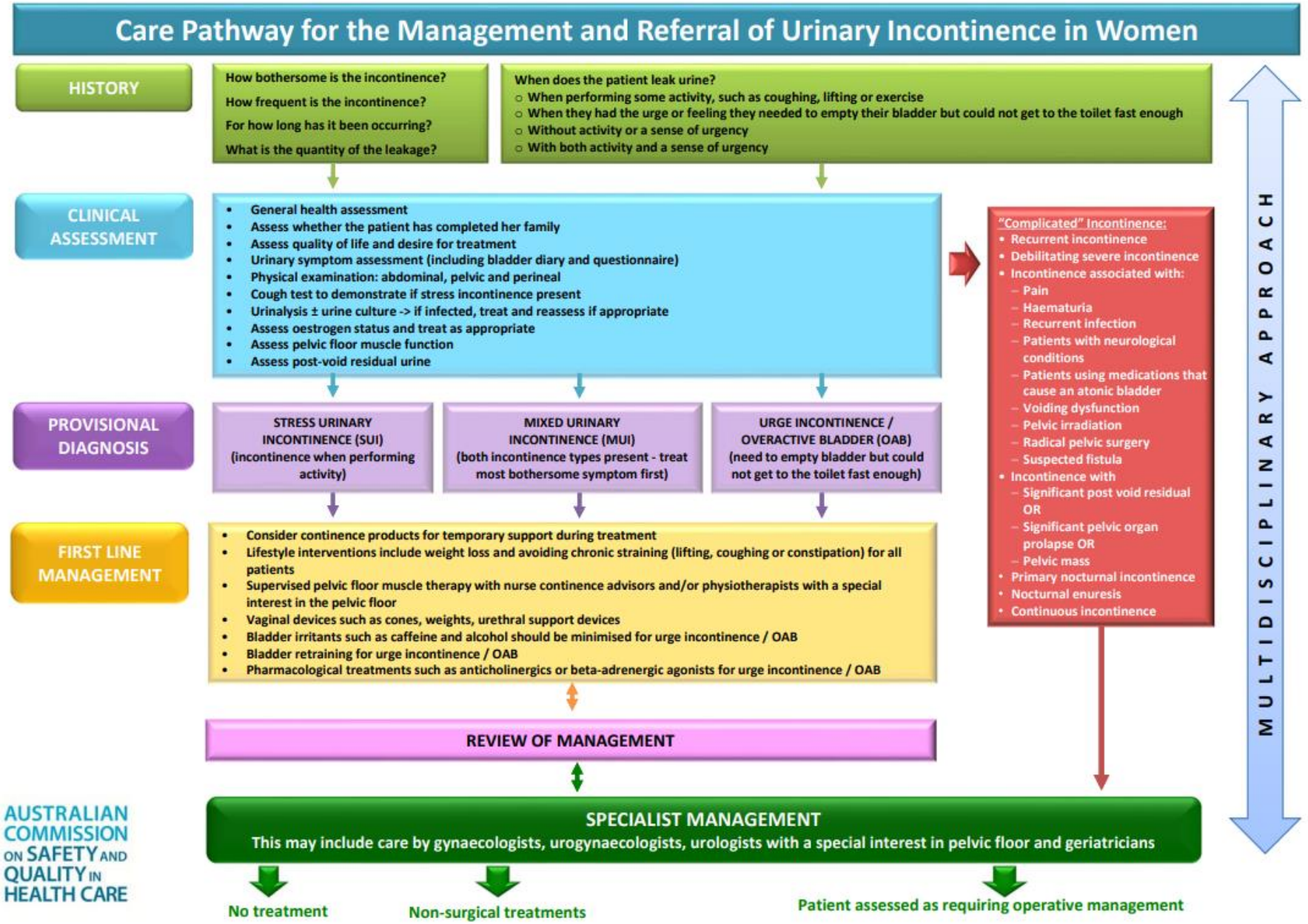


Australian Commission on Safety and Quality in Healthcare – [Care Pathway for the Management and Referral of Urinary Incontinence in Women]

Urinary Incontinence Management

- Consider GP Management Plan/Team Care Arrangements or Public Physiotherapy Service Referral
- Commence advice re Pelvic floor muscle training (PFMT)
- Bladder & bowel retraining
- Weight optimisation
- Treat constipation (and obesity/chronic cough if possible)
- Topical oestrogen in post-menopausal women (or MHT if significant menopausal symptoms and no contraindications)
- Urge incontinence/overactive bladder
    - Anti-cholinergic (oxybutynin, solifenancin) *
    - Beta 3 agonist (mirabegron)
    - Intravesical Botulinum toxin A
    - Sacral Nerve Stimulator
- Surgery

* Anticholinergic drugs for overactive bladder William Kuteesa, Kate H. Moore; Aust Prescriber 2006;29:22-4 https://doi.org/10.18773/austprescr.2006.012

Management of urinary incontinence in adults. Kim S, Liu S, Tse V. Aust Prescriber 2014;37:10-3 https://doi.org/10.18773/austprescr.2014.003

RED FLAG

Require more urgent Urology/Gynaecologist review

"Complicated" Incontinence:

- Recurrent incontinence
- Debilitating severe incontinence
- Incontinence associated with:
  - Pain
  - Haematuria
  - Recurrent infection
  - Patients with neurological conditions
  - Patients using medications that cause an atonic bladder
  - Voiding dysfunction
  - Pelvic irradiation
  - Radical pelvic surgery
  - Suspected fistula
- Incontinence with
  - Significant post void residual OR
  - Significant pelvic organ prolapse OR
  - Pelvic mass
- Primary nocturnal incontinence
- Nocturnal enuresis
- Continuous incontinence

Urological Referral:

Request acute urology assessment : ED REFERRAL

- acute urinary retention
- suspected cauda equina syndrome

Request non-acute urology assessment and mark as urgent if: CATEGORY 1 Referral

- concerning features.
  - Suspected malignant pelvic mass.
  - Haematuria or sterile pyuria.
  - Significant dysuria or severe irritative symptoms.
  - Elevated post-void residuals (> 300 mL) and hydronephrosis on ultrasound and/or altered renal function.
  - Known or suspected neurogenic bladder, persistent bladder pain
  - Suspected urogenital fistulae.
- overflow incontinence.

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

Urological Referral:

Request non-acute urology assessment if:

- severe incontinence requiring multiple (> 2) pad changes per day.
- nocturnal incontinence.
- associated faecal incontinence.
- post-void residual > 100 mL
- incontinence requiring 1 to 2 pad changes per day and any severe symptoms or failed therapy

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

Minimum referral criteria (Does your patient meet the minimum criteria?)

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	▸ Suspected malignant mass ▸ Bladder outlet obstruction ▸ Haematuria or sterile pyuria ▸ Elevated post-void residuals (> 300mls) and hydronephrosis on USS and/or altered renal function ▸ Known or suspected neurogenic bladder ▸ Suspected urogenital fistulae
Category 2 (appointment within 90 calendar days)	▸ Incontinence requiring multiple (> 2) pad changes per day ▸ Nocturnal incontinence ▸ Post-void residual > 100ml ▸ Associated faecal incontinence ▸ Moderate to severe pelvic organ prolapse

Category 3
(appointment within 365 calendar days)
	▸ Incontinence requiring 1-2 pad changes per day and any of the following:
	  ▸ recurrent (> 3 per year) or persistent UTI
	  ▸ persisting bladder or urethral or perineal pain
	  ▸ socially limiting (severe)
	  ▸ failed physiotherapy/continence nurse management
	  ▸ failed anti-cholinergic and beta3 adrenergic agonist therapy

Incontinence/bladder dysfunction (female) | Referrals to Urology | Metro South Health

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)

Continence Foundation of Australia

Search

Helpline 1800 33 00 66

Speak to a Nurse Continence Specialist

Resources | Other languages | Text to speech | - Aa +

[Incontinence prevention, management & support | Continence Foundation of Australia]

Home | Incontinence | Continence Health | Get Help | Events | Get involved | For Professionals | About us | Login | 0 items

Understanding incontinence

Types of Incontinence

Who it affects

Medical conditions

Personal stories

Digital magazine

INCONTINENCE MANAGEMENT

Live your life to the fullest

Preventing incontinence

In many cases, incontinence can be prevented with a healthy diet and lifestyle habits.

Learn more

Life with incontinence

With some planning, incontinence doesn't need to hold you back.

Learn more

Caring for someone

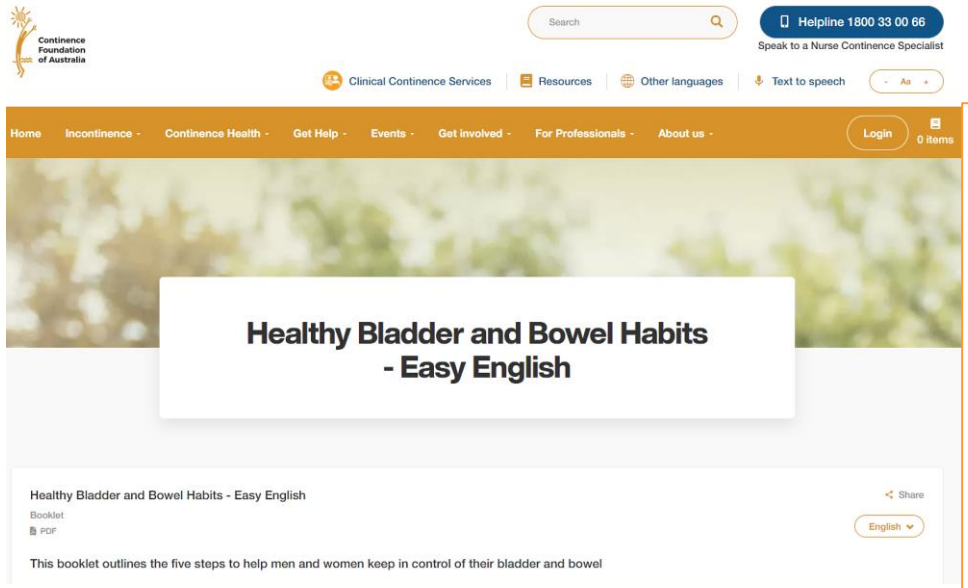
Practical tips and information to assist you in your care.

Learn more

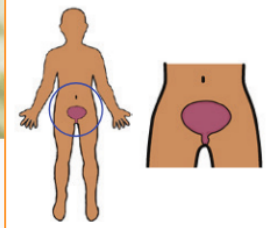
5 Healthy Habits for Bowel and Bladder Health

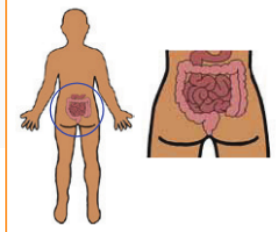
Let our 5 healthy habits be your guide to a healthier and more independent future.

Learn more



[Healthy Bladder and Bowel Habits - Easy English]





Healthy bladder and bowel habits

This factsheet is about how to keep your **bladder** and **bowel** healthy.

This factsheet has some hard words.
The first time we write a hard word it is **blue**.
We will say what the hard word means.

The words and pictures in this factsheet will help you learn about things in your body.
The pictures do **not** show all the detail.

4. Have good toilet habits

Wait until your bladder feels full before you do a wee.

Poo when you need to. Holding poo in can give you constipation.

Take your time on the toilet.

Sit on the toilet in the right way. Try to

- lean forward
- put your elbows on your knees

HEALTHY HABITS FOR YOUR BLADDER AND BOWEL

5 Healthy Habits

ABOUT THE 5 HEALTHY HABITS

The Continence Foundation of Australia encourages older Australians to invest time in 5 healthy habits to help prevent incontinence. These 5 healthy habits are important for Bladder and Bowel Health.

These habits include a healthy diet and staying hydrated, 30 minutes of exercise every day and good toilet habits.

Webinars on each of the 5 healthy habits can be viewed. These include topics such as increasing dietary fibre in cooking without losing flavour, making exercise part of your day, and how to keep your pelvic floor in shape.

View the 5 healthy habits and our webinars below.

HABIT 1 – STAY ACTIVE

Physical activity is beneficial for overall health – and that includes bladder and bowel function! Aim for at least 30 minutes of physical activity per day. This doesn't have to be all at once. Activities like gardening, cleaning, playing with the grandkids, and taking the stairs all add up.

Making a move in the right direction, not matter how small, can make a big difference.

HABIT 2 – EAT WELL

Fibre in your diet will help improve bowel function and avoid constipation. Fibre is found in foods such as multi grain or whole grain breads, cereal products, fruit, vegetables, legumes, and nuts and seeds. Aim to eat two servings of fruit, five servings of vegetables and five servings of cereals and breads each day.

You are what you eat, and eating well can make a world of difference to how we feel and how our bodies operate.

HABIT 3 – GET ENOUGH FLUIDS AND DRINK WELL

It's important to increase fluids when you increase fibre in your diet. Drinking plenty of water and staying hydrated helps maintain digestive health. Drinks that contain caffeine, cola and alcohol can irritate your bladder, so water is the best choice.

While our tendency when dealing with bladder and bowel problems might be to restrict our liquid intake, this is actually the opposite of what we should do.

HABIT 4 – EXERCISE YOUR PELVIC FLOOR

Having a strong pelvic floor is your insurance against incontinence. You can train your pelvic floor anytime, anywhere, no matter what sex, gender, age or fitness level you are.

Try to do your pelvic floor muscles exercises every day, three times a day. See a continence health professional to learn how.

Making a move in the right direction, not matter how small, can make a big difference.

HABIT 5 – PRACTICE GOOD TOILET HABITS

Don't get into the habit of going to the toilet 'just in case'. If you keep emptying your bladder 'just in case' too often, then the bladder may never fill up properly, and shrink a bit. This may give the feeling of needing to go to the toilet more frequently (urge incontinence).

Surprisingly, there are a few things you can do to make your visit to the toilet as effective as possible. Try these today.

Good Toilet Habits webinar +

One call could be all it takes

NATIONAL CONTINENCE HELPLINE

Speak to a continence nurse and receive information, support and advice

1800 33 00 66

RELATED CONTENT

- About your bowel
- Bristol Stool Chart
- Diarrhoea
- Constipation

DOWNLOAD RESOURCES

- Caring for someone with bladder & bowel problems
- Bowel diary
- Looking after your bowel: A guide to improving bowel function
- Poor bowel control
- Healthy bladder and bowel habits
- Healthy diet and bowels

Share
Print
Text to speech
Send feedback

Continence Foundation of Australia

OTHER LANGUAGES

Incontinence information in other languages

The following pages include factsheets and videos in 30 different languages on pelvic floor exercises for men and women, bladder leakage, childhood bedwetting, constipation and bowel control, prostate and bladder problems and healthy bladder and bowel habits.

عربی Arabic	ဗမာစာ Burmese	廣東話 Cantonese	hrvatski Croatian
دری Dari	Thuɔŋjäŋ Dinka	Nederlands Dutch	English English
Pilipino Filipino	Deutsch German	Ελληνικά Greek	नेपाली Hindi
Magyar Hungarian	Indonesia Indonesian	Italiano Italian	日本語 Japanese
ကညီကျိာ် Karen	한국어 Korean	македонски Macedonian	Malti Maltese
普通话 Mandarin	فارسی Persian	Polski Polish	српски Serbian
Soomaali Somali	Español Spanish	தமிழ் Tamil	Türkçe Turkish
اردو Urdu		Tiếng Việt Vietnamese	

ADDITIONAL LANGUAGES

Our 'One in three women who ever had a baby wet themselves' factsheet is now available in three new languages: Hakha Chin, Khmer and Punjabi.

'Men's Incontinence' video is now available in two new languages: Swahili and Punjabi.

GUIDELINES FOR INTERPRETERS

Guidelines for Interpreters – What to Expect in a Continence Assessment factsheet.

Continence Foundation of Australia

Your bowel diary

To help understand how to treat or better manage your bowel control, a health professional may ask you to keep a bowel diary.

A bowel diary is a record you keep of the times and types of bowel motions (poo or stool) you passed or leaked. When you record this information over a few days, you may start seeing patterns.

These patterns may help work out what is causing the problem or how to better manage it. For example, you may only be having problems during certain parts of the day or night, or after certain food or drinks.

Your doctor, nurse continence specialist or pelvic health physiotherapist will use this information as part of your continence assessment.

How do I fill in a diary?

- Record information for a full week (7 days in a row)
- Follow the example given at the top of the diary to help you fill it out correctly
- Use the Bristol Stool Chart (Figure 1.) to help describe your bowel motions

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, mushy stool
Type 7		Watery, no solid pieces. ENTIRELY LIQUID

Figure 1 - Bristol Stool Chart

Developed by K.W. Heaton & S.J. Lewis at the University of Bristol and first published in the Scandinavian Journal of Gastroenterology in 1997. © Norgine Ltd

What is a continence assessment?

In a continence assessment, your health professional will ask you a few questions, do a physical check and may ask for more tests to be done.

Based on the results of your assessment, they will then prepare a plan for you to help treat or better manage your bowel issue. The plan can include:

- changes to your diet or fluid intake
- pelvic floor muscle exercises
- changes to your medications.

Other fact sheets

- Healthy diet and bowels
- Pelvic floor muscle exercises for men
- Pelvic floor muscle exercises for women
- Continence products
- Poor bowel control
- Looking after your bowel

More information and advice

The Continence Foundation of Australia is the national peak body for continence prevention, management, education, awareness, information and advocacy
Website continence.org.au

The National Public Toilet Map shows the location of public and private toilet facilities across Australia
Website toiletmap.gov.au

Call the National Continence Helpline on 1800 33 00 66 (free call)

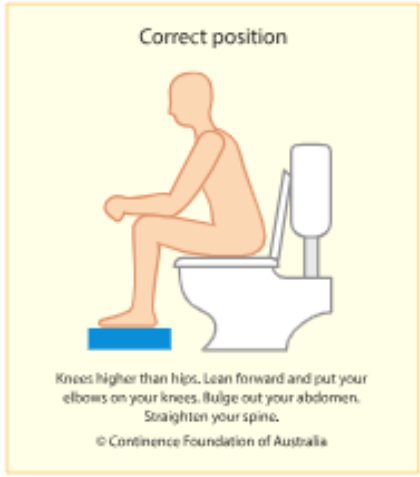
Speak with a nurse continence specialist for free and confidential advice on resources, details for local continence services, products and financial assistance.

For more information, you can also visit:

continence.org.au
toiletmap.gov.au
health.gov.au/bladder-bowel

This fact sheet is intended as a general overview only and is not a substitute for professional assessment and care.

Bladder & bowel resources | Continence Foundation of Australia



Name:

Bowel Diary
Fill in this diary for about seven days in a row. Use with the Bristol Stool Chart.

Day and time		Bowel movement				Pads or clothing	Bowel medication What and when	What happened at the time you passed a bowel motion?
Day	Time	Stool (poo) type (Bristol Stool Chart Type 1-7)	How urgent was your need to use your bowels (poo)? 1 = no urge to 3 = normal urge to 5 = strong urge	Did you leak or soil? (Yes or No)	How much did you leak or soil? (Smear, small, medium or large)	Did you change your pad or clothing? (Yes or No)	Did you take any laxatives, fibre supplements, enemas, suppositories etc?	Where you were, or what you were doing at the time of the accident/soiling
Example: Saturday 3 March	*9.00am*	*5*	*1*	*Yes - both wee and poo*	*Medium*	*Yes - my underpants and jeans*	*Psyllium husks the night before*	*Went for a walk after breakfast. Did not realise I leaked wee and poo at the time*

Continence Foundation of Australia
https://www.continence.org.au/resource/your-bladder-diary

Your Bladder Diary | Continence Foundation of Australia

Web A bladder diary is a record you keep of when and how much urine you passed or leaked during the day and overnight. Download a fact sheet PDF to learn how to use it for your …

Tags: Bladder Diary Bladder Health

Your Bladder Diary – DOWNLOAD

The National Public Toilet Map

The National Public Toilet Map is a free website and App that shows the location of more than 22,000 public toilet facilities across Australia. This is useful map for all Australians when they are moving around the community especially people with incontinence, travelers, or young families.

Access the National Public Toilet Map

What is the National Public Toilet Map?
Where can I access the National Public Toilet Map?
What features are available on the National Public Toilet Map?
What are some tips for travelling with incontinence?
Download promotional resources for the National Public Toilet Map

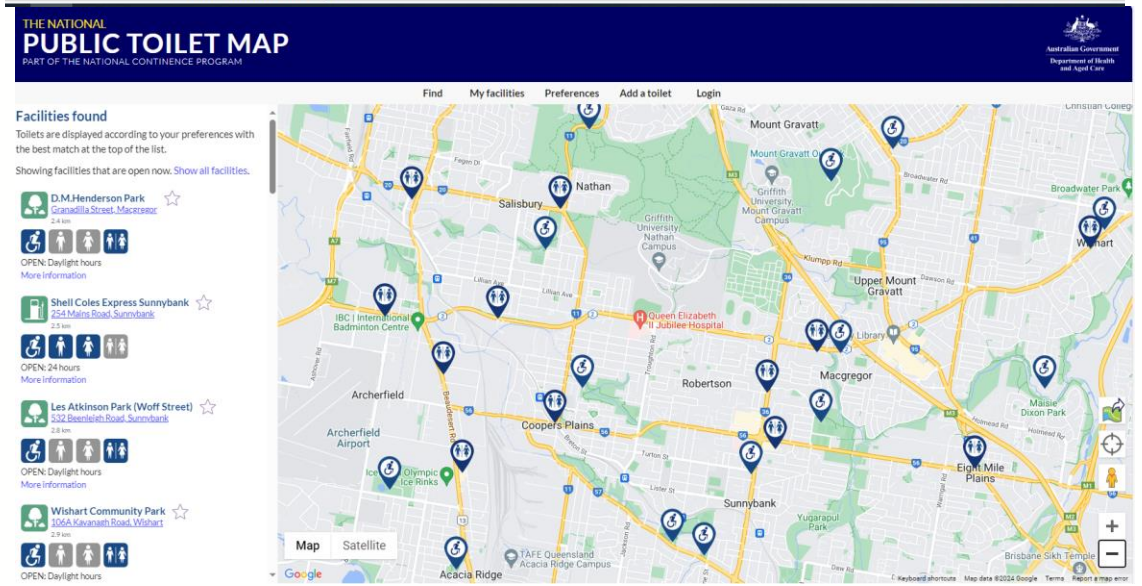
WHAT IS THE NATIONAL PUBLIC TOILET MAP?

The National Public Toilet Map provides:

- The location of the nearest public toilet
- Details of opening hours, accessibility, parking and many other features
- The ability to add and update public toilets and their facilities
- Specialty maps, with the ability to share maps
- Distance by route, which calculates and displays the travel distance to facilities. This takes into account one-way streets and access to buildings, whether on foot or in a car.

One call could make a difference
NATIONAL CONTINENCE HELPLINE
1800 33 00 66

The National Public Toilet Map is funded by the Australian Government Department of Health and Aged Care as part of the National Continence Program.

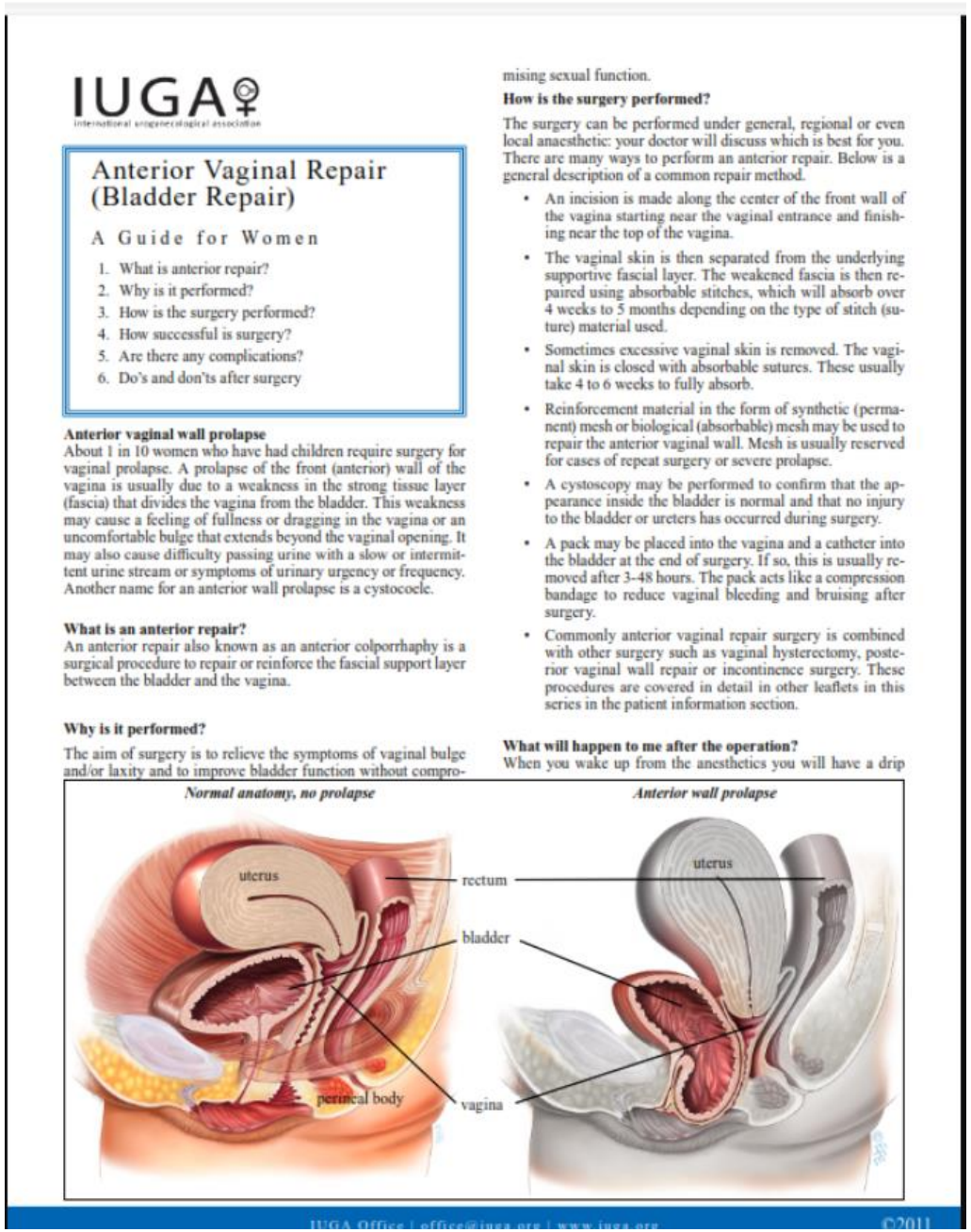


- One example of many different pamphlets from International Urogynaecological Association (IUGA)
- Also available in many languages
- [Patient Leaflets - Your Pelvic Floor]

Leaflets

IUGA is pleased to offer **Patient Information Leaflets** in pdf format for convenient download. For optimal viewing, please download or upgrade to the latest version of **Adobe Reader** to view the pdf files by clicking here.

Providers:
IUGA patient education leaflets are also available in printed brochure format. To order, visit our Online Store at www.iugastore.com.
Please Note: Brochure format is not available in every language.



IUGA
international urogynecological association

Anterior Vaginal Repair (Bladder Repair)

A Guide for Women

1. What is anterior repair?
2. Why is it performed?
3. How is the surgery performed?
4. How successful is surgery?
5. Are there any complications?
6. Do's and don'ts after surgery

Anterior vaginal wall prolapse
About 1 in 10 women who have had children require surgery for vaginal prolapse. A prolapse of the front (anterior) wall of the vagina is usually due to a weakness in the strong tissue layer (fascia) that divides the vagina from the bladder. This weakness may cause a feeling of fullness or dragging in the vagina or an uncomfortable bulge that extends beyond the vaginal opening. It may also cause difficulty passing urine with a slow or intermittent urine stream or symptoms of urinary urgency or frequency. Another name for an anterior wall prolapse is a cystocoele.

What is an anterior repair?
An anterior repair also known as an anterior colporrhaphy is a surgical procedure to repair or reinforce the fascial support layer between the bladder and the vagina.

Why is it performed?
The aim of surgery is to relieve the symptoms of vaginal bulge and/or laxity and to improve bladder function without compromising sexual function.

How is the surgery performed?
The surgery can be performed under general, regional or even local anaesthetic: your doctor will discuss which is best for you. There are many ways to perform an anterior repair. Below is a general description of a common repair method.

- An incision is made along the center of the front wall of the vagina starting near the vaginal entrance and finishing near the top of the vagina.
- The vaginal skin is then separated from the underlying supportive fascial layer. The weakened fascia is then repaired using absorbable stitches, which will absorb over 4 weeks to 5 months depending on the type of stitch (suture) material used.
- Sometimes excessive vaginal skin is removed. The vaginal skin is closed with absorbable sutures. These usually take 4 to 6 weeks to fully absorb.
- Reinforcement material in the form of synthetic (permanent) mesh or biological (absorbable) mesh may be used to repair the anterior vaginal wall. Mesh is usually reserved for cases of repeat surgery or severe prolapse.
- A cystoscopy may be performed to confirm that the appearance inside the bladder is normal and that no injury to the bladder or ureters has occurred during surgery.
- A pack may be placed into the vagina and a catheter into the bladder at the end of surgery. If so, this is usually removed after 3-48 hours. The pack acts like a compression bandage to reduce vaginal bleeding and bruising after surgery.
- Commonly anterior vaginal repair surgery is combined with other surgery such as vaginal hysterectomy, posterior vaginal wall repair or incontinence surgery. These procedures are covered in detail in other leaflets in this series in the patient information section.

What will happen to me after the operation?
When you wake up from the anesthetics you will have a drip

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

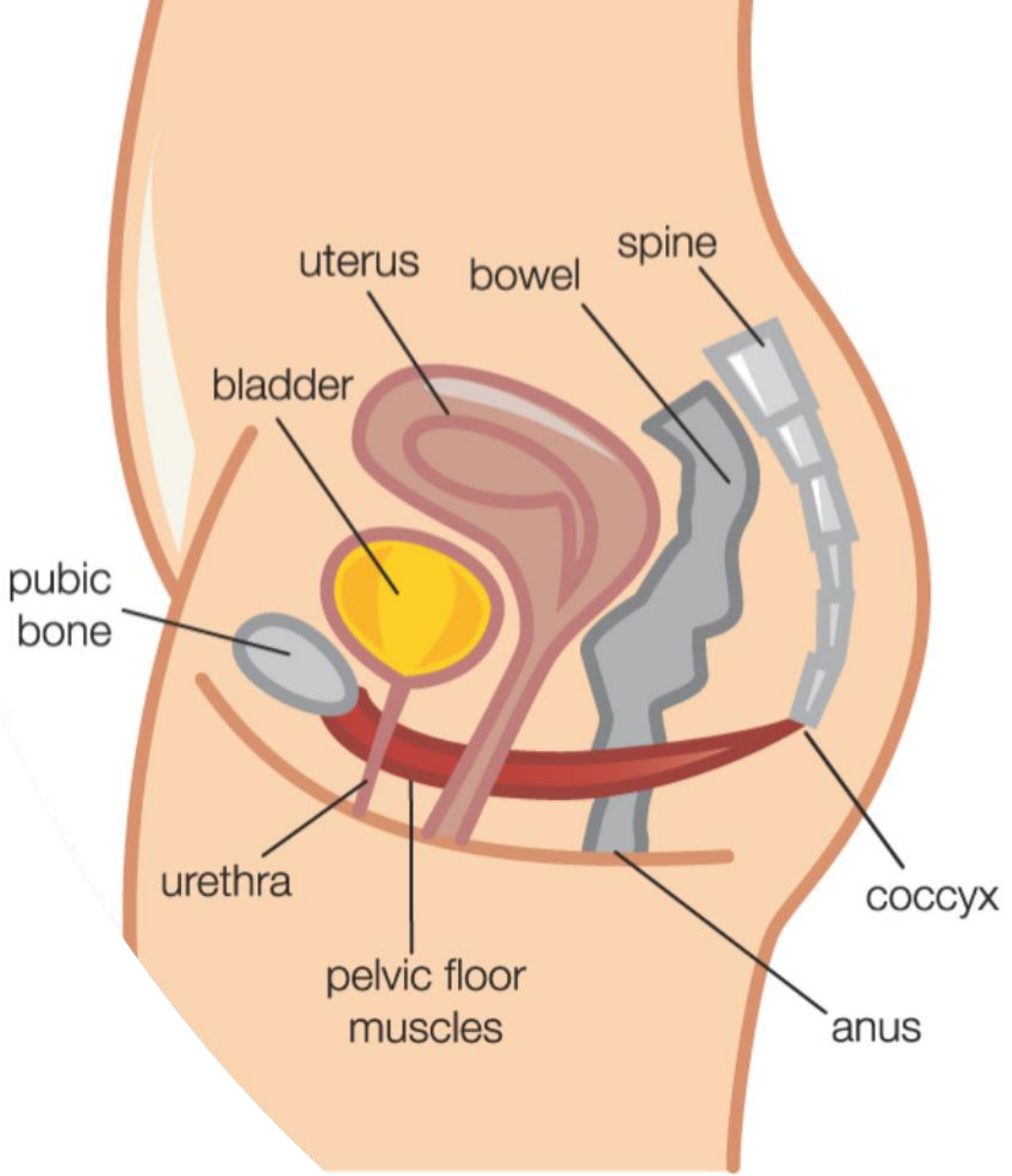
- Maternity Inpatient Unit (2hrs each weekday)

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 the SMART Referral Workflow Solution
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.

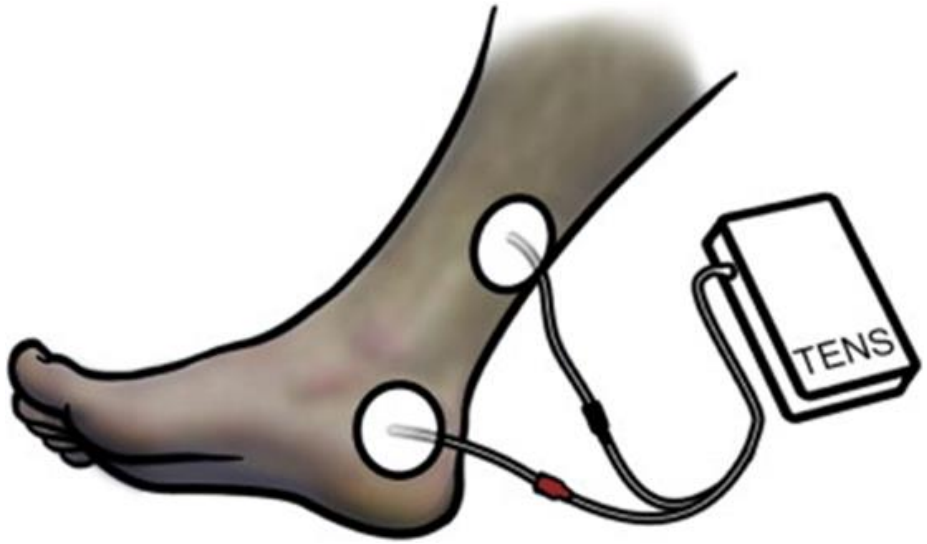
Physiotherapy Management Overview

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

Physiotherapy Management- Urinary dysfunction

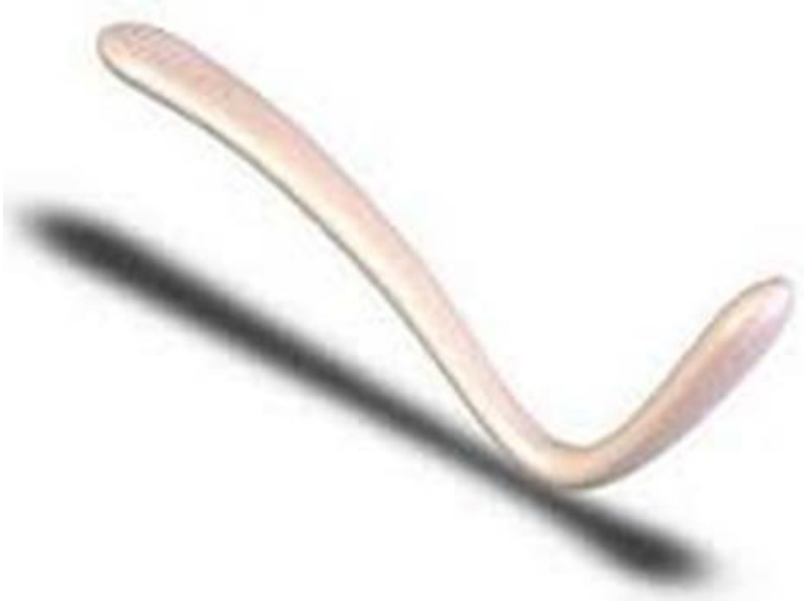
i.e. Urinary Incontinence, Voiding dysfunction, Bladder urgency

- 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

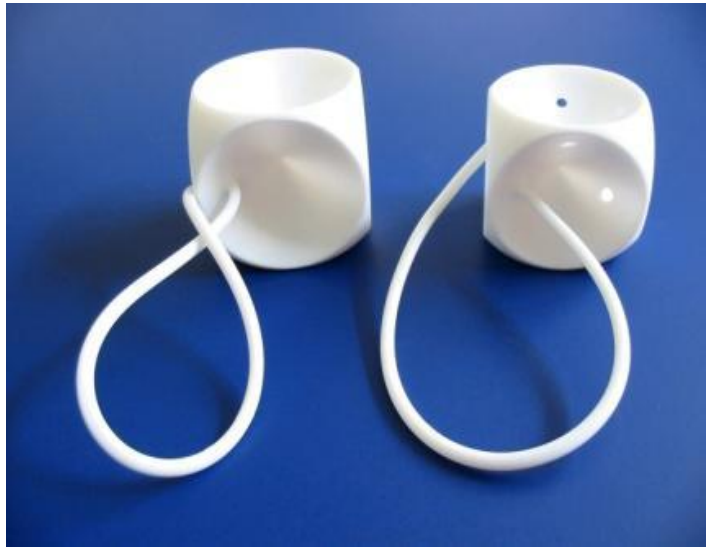
- Pain management
  - Pain neuroscience education
  - Downtraining
  - Biofeedback
  - Desensitisation
  - Soft tissue release
  - Neuromodulation

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
1:45 pm	Hands –On Practical Demonstrations - Speculum Use - Implanon Insertions - IUD Insertion - Pelvic Floor Muscle Anatomy - Pipelle Biopsy Demo - Q & A with Gynaecologist	Breakout Group Rotations	Facilitated groups Power Point Presentation & Forum Discussion
2:45 pm	Case Discussion – Pelvic Pain/Endometriosis	Group Spokesperson Dr Katie Christensen	Facilitated groups Power Point Presentation & Forum Discussion
3:45 pm	Wrap Up CPD Discussion – Self Logging	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

Orange Group Task

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 Katie Christiansen
Director of Gynaecology
QEII Surgical Services

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

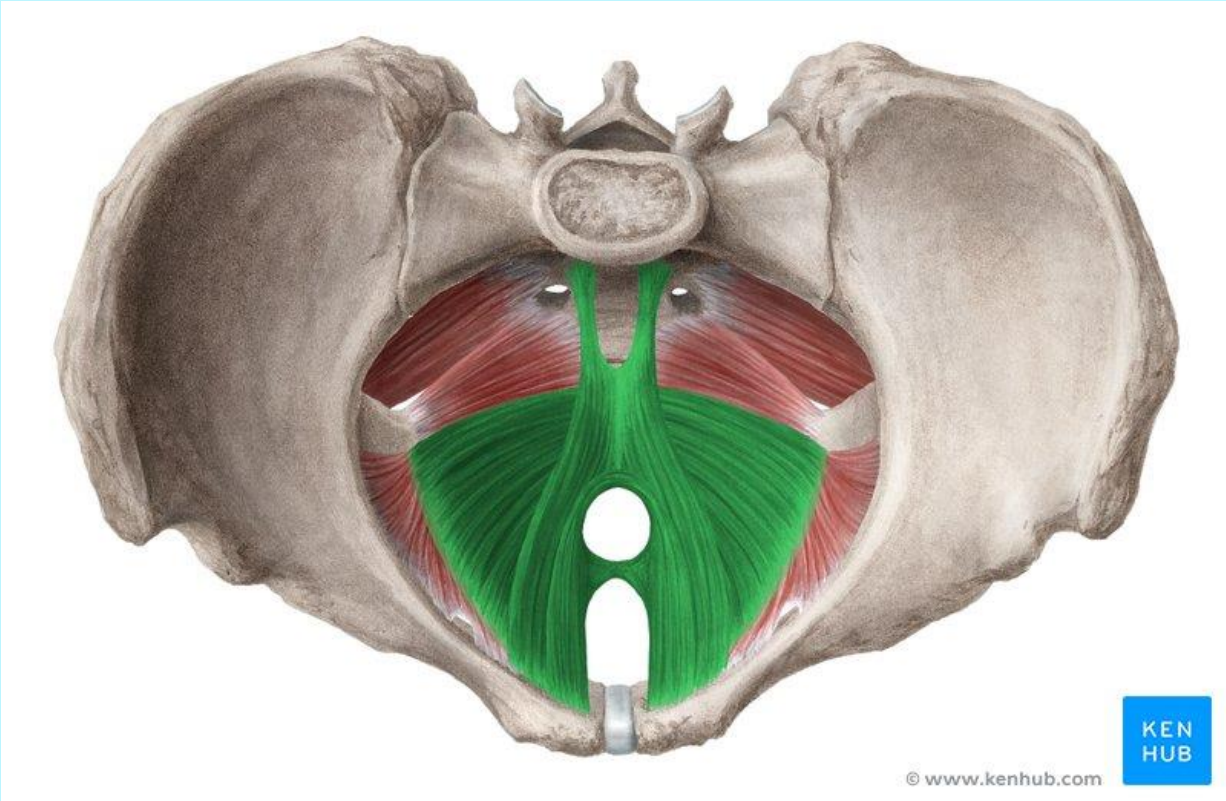
- What have you tried so far/currently using
  - Hormonal
  - Pain relief
    - NSAIDs – what and how do you use
    - Opioids/other
    - Neuromodulators – what/how used/duration/adverse effects?
  - Physio? Psych?
  - TENS
  - Flare management currently?
- Usual history (FHx/PMH/PSH/O&G/meds/Social)
  - 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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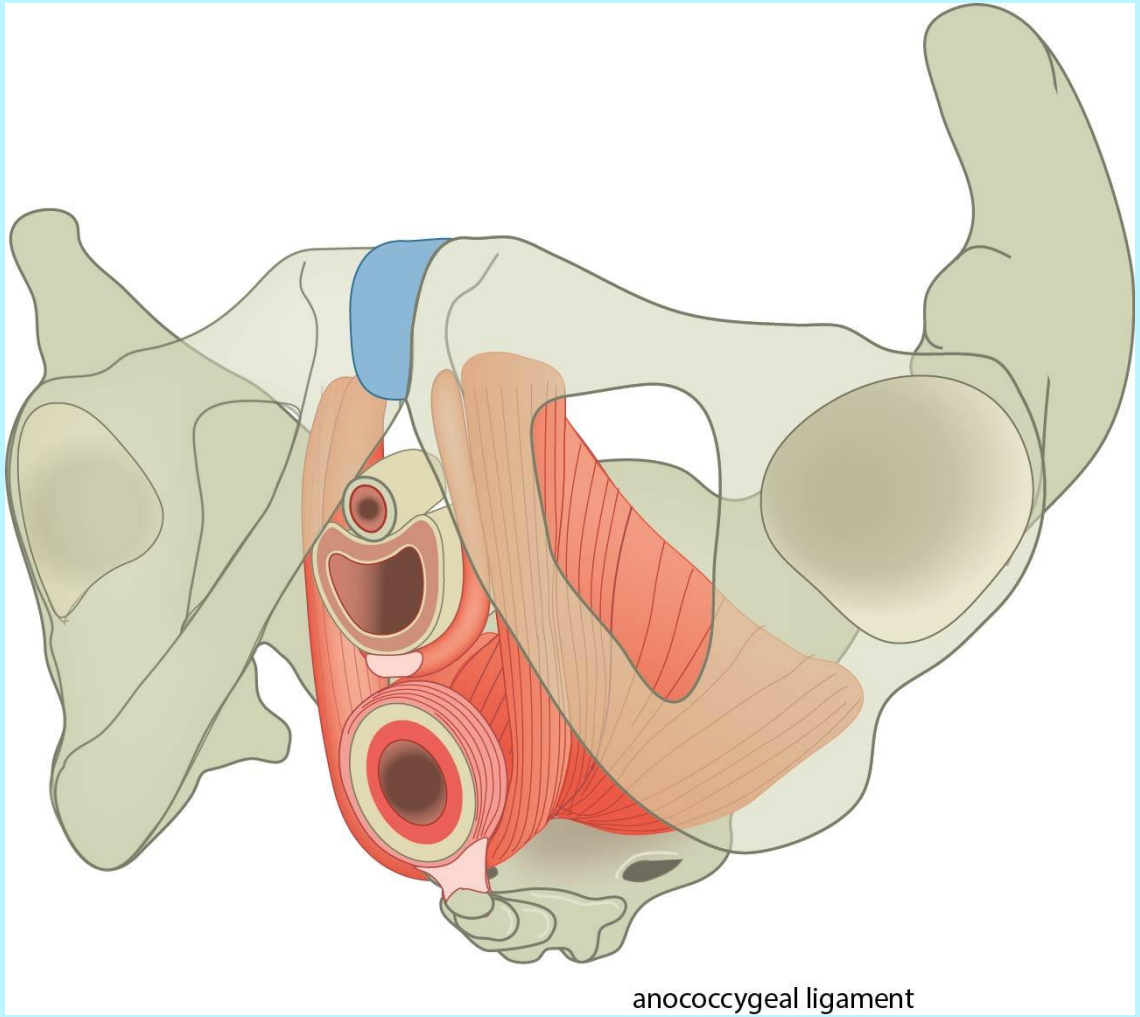
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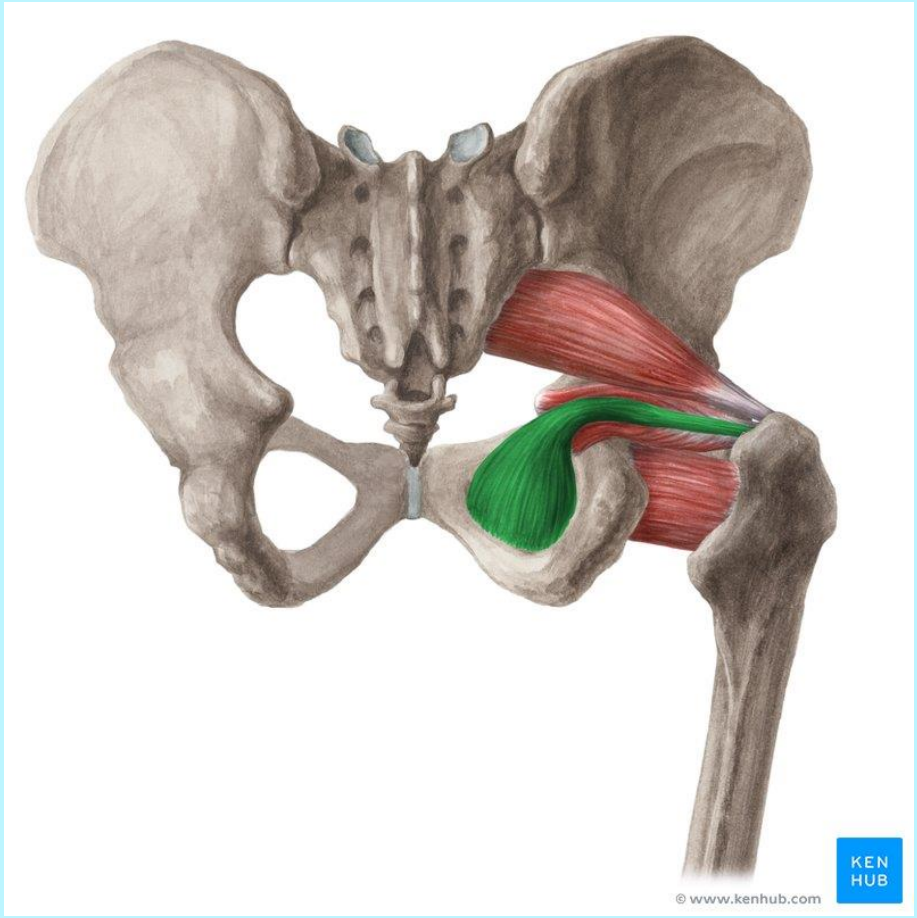
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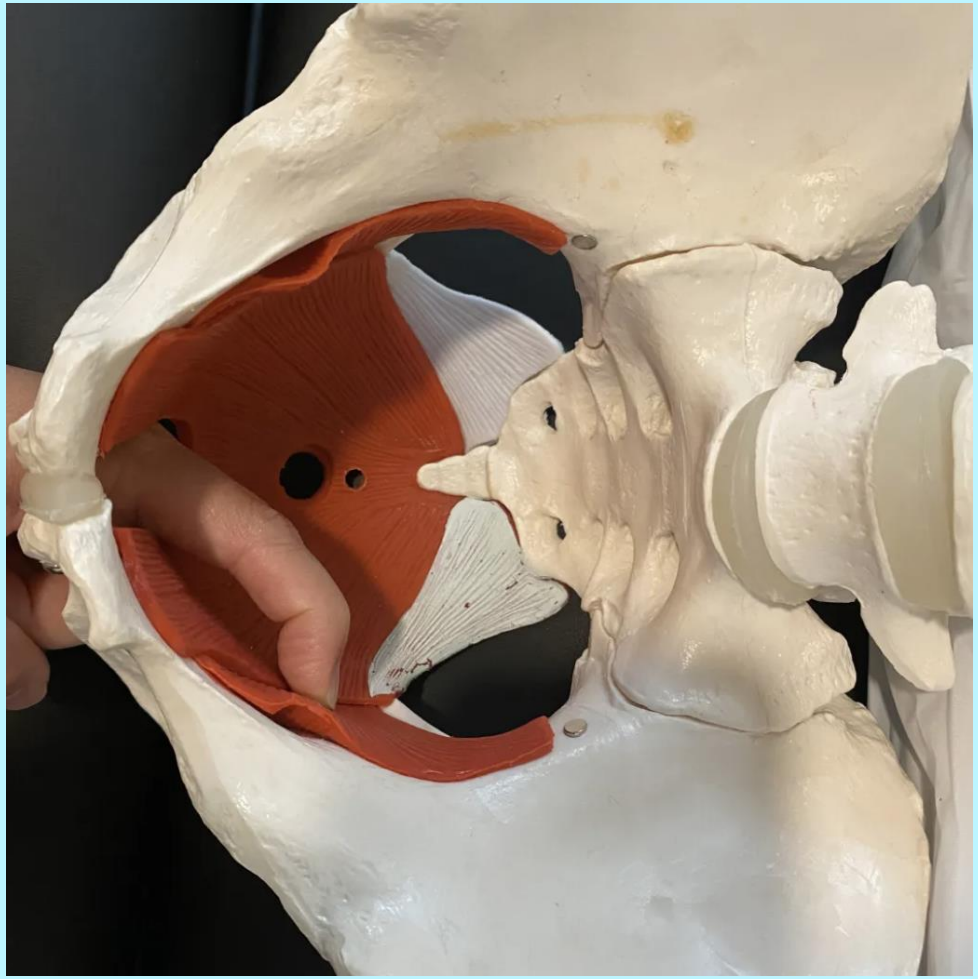
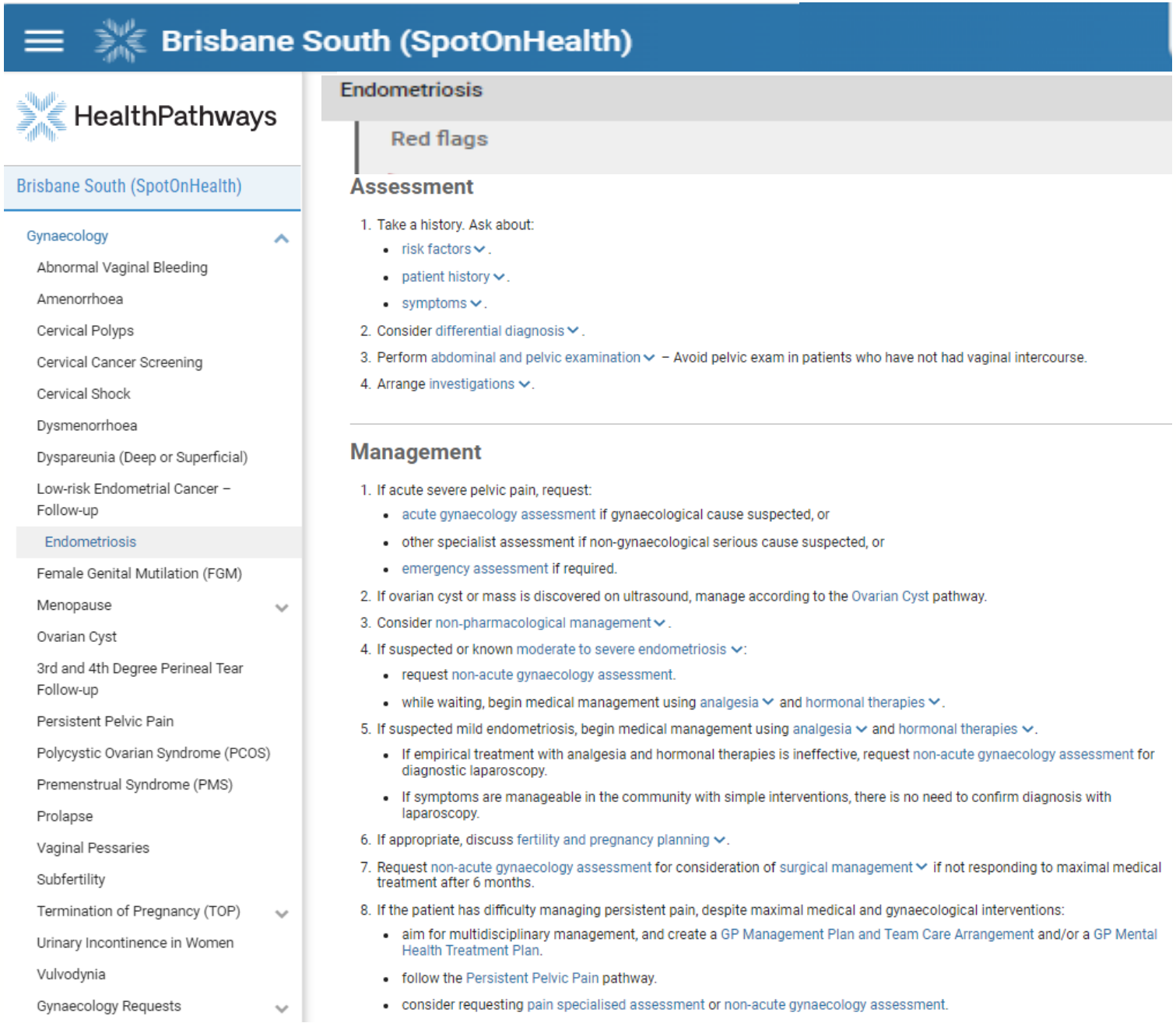




https://brisbanesouth.communityhealthpathways.org/30280.htm

- 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)

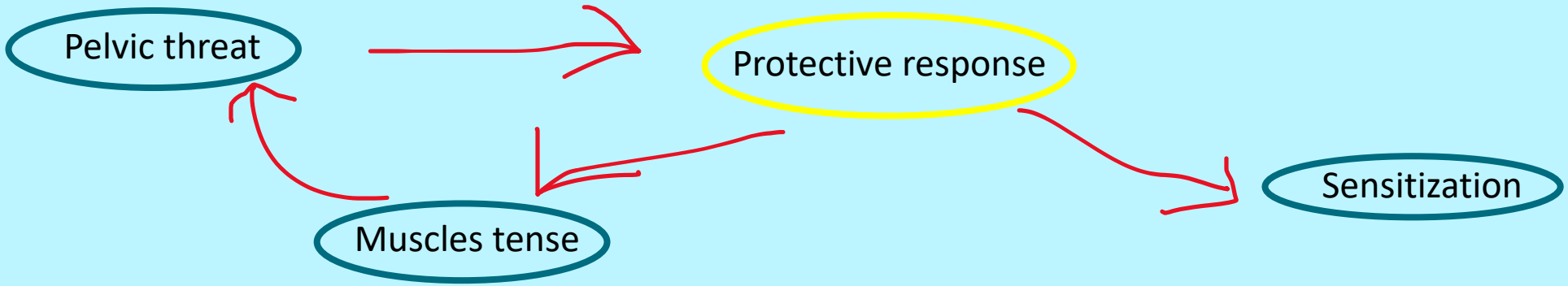
RED FLAGS

- 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

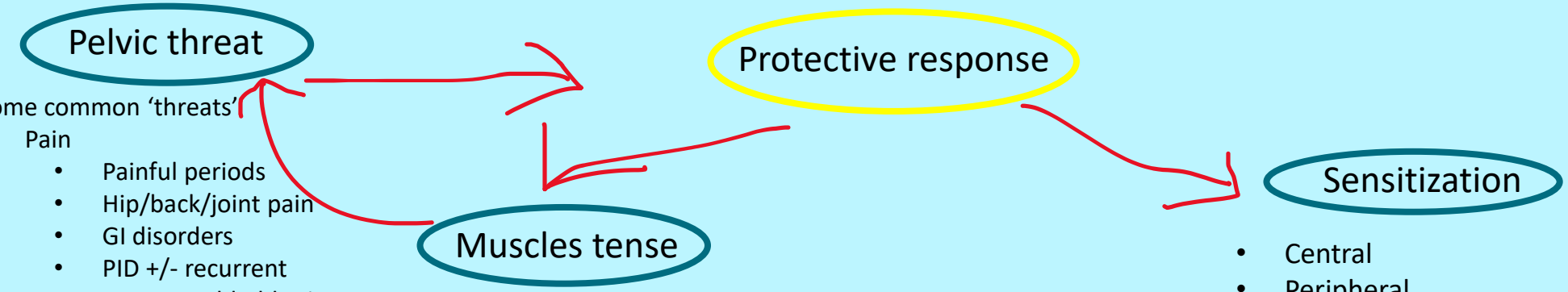
- Think of:
  - Original driver/s of pain?
  - Organ dysfunction – reproductive, bladder, bowel
  - MSK response to pain
  - Central sensitisation
  - Psychological sequelae of pain

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

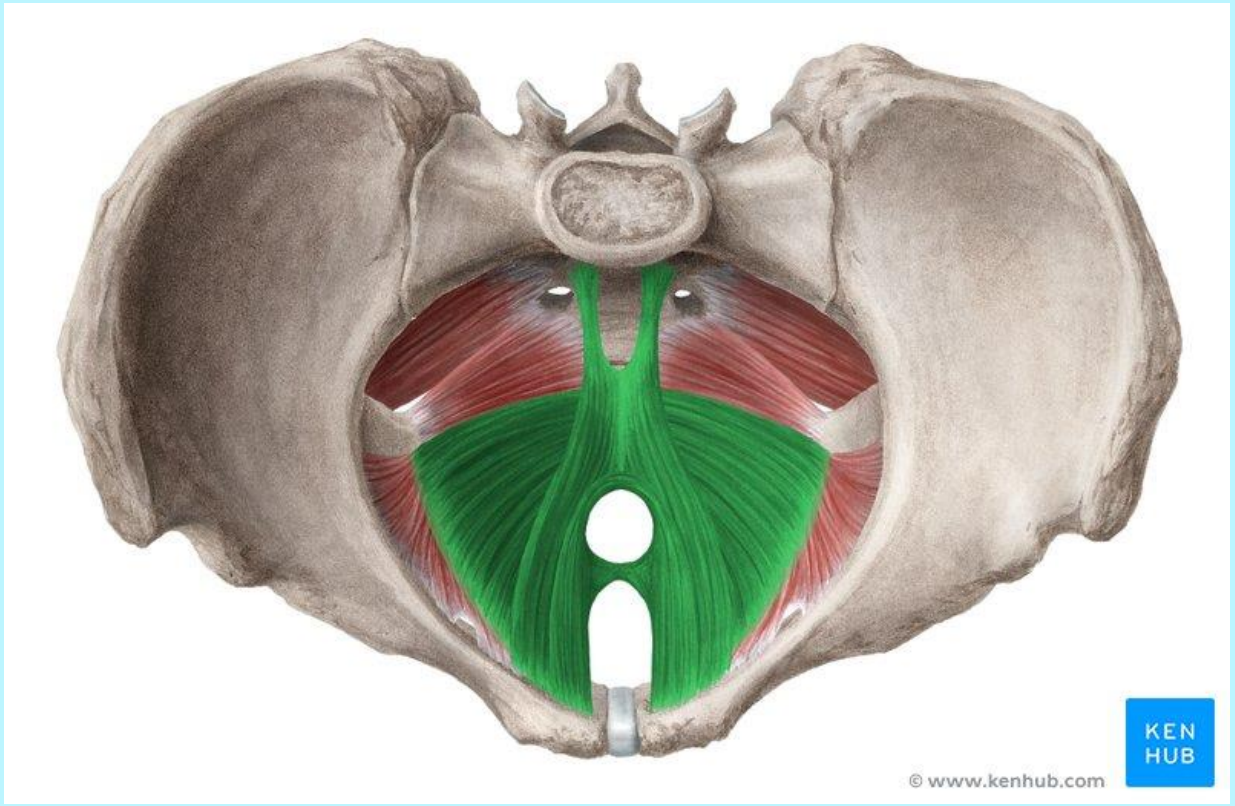
- Occ – Botox to pelvic muscles
- Flare mx:
  - Breathing, stretches
  - Mindfulness
  - Heat
  - NSAIDs – optimize dosing
  - Diazepam supps

- 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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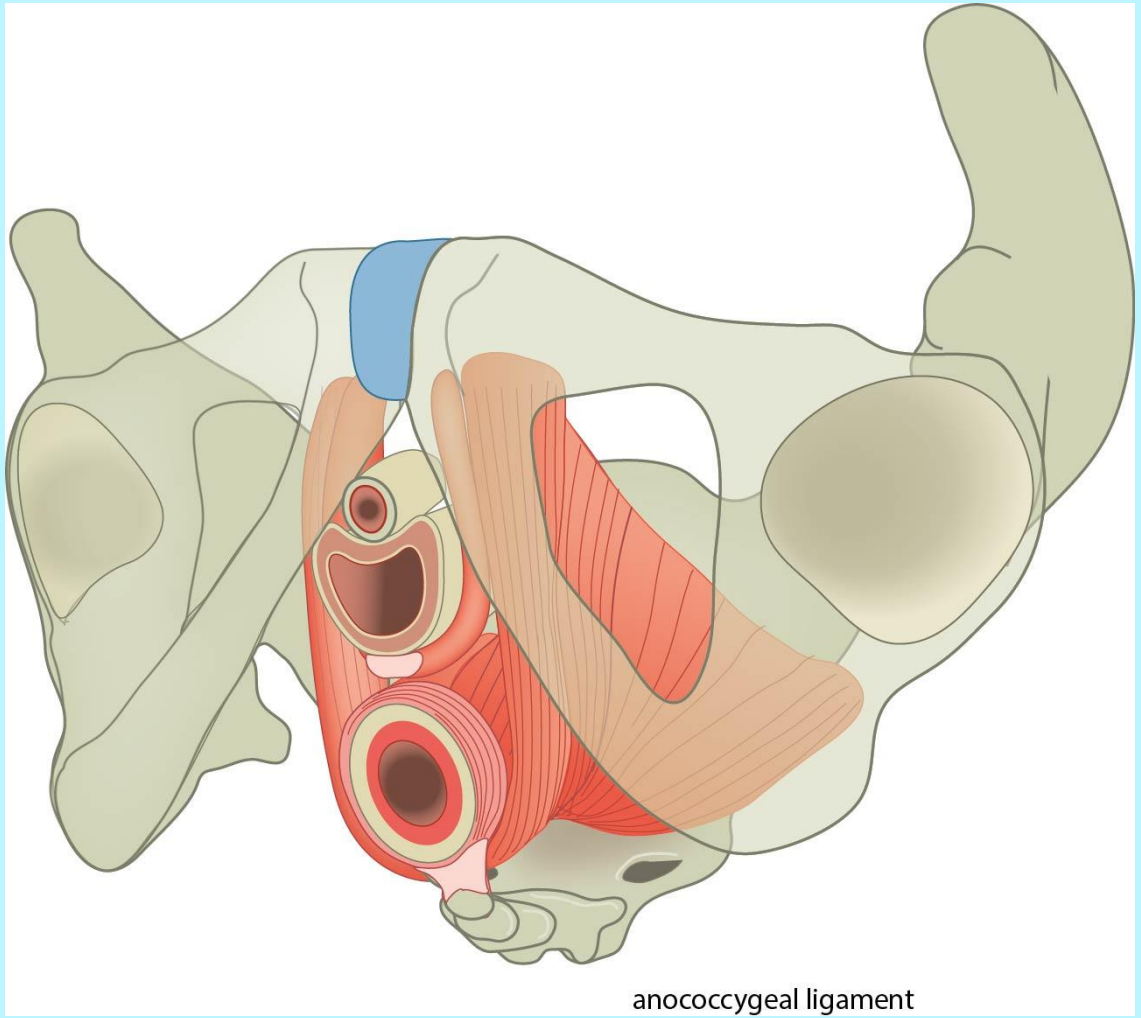
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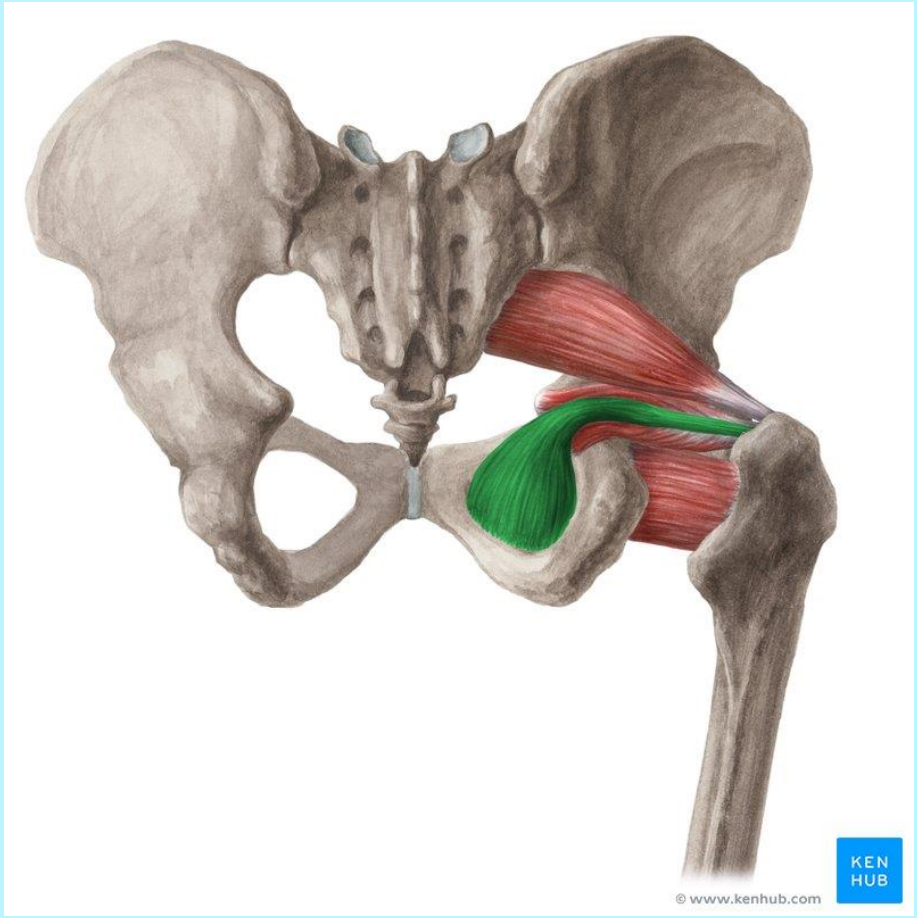
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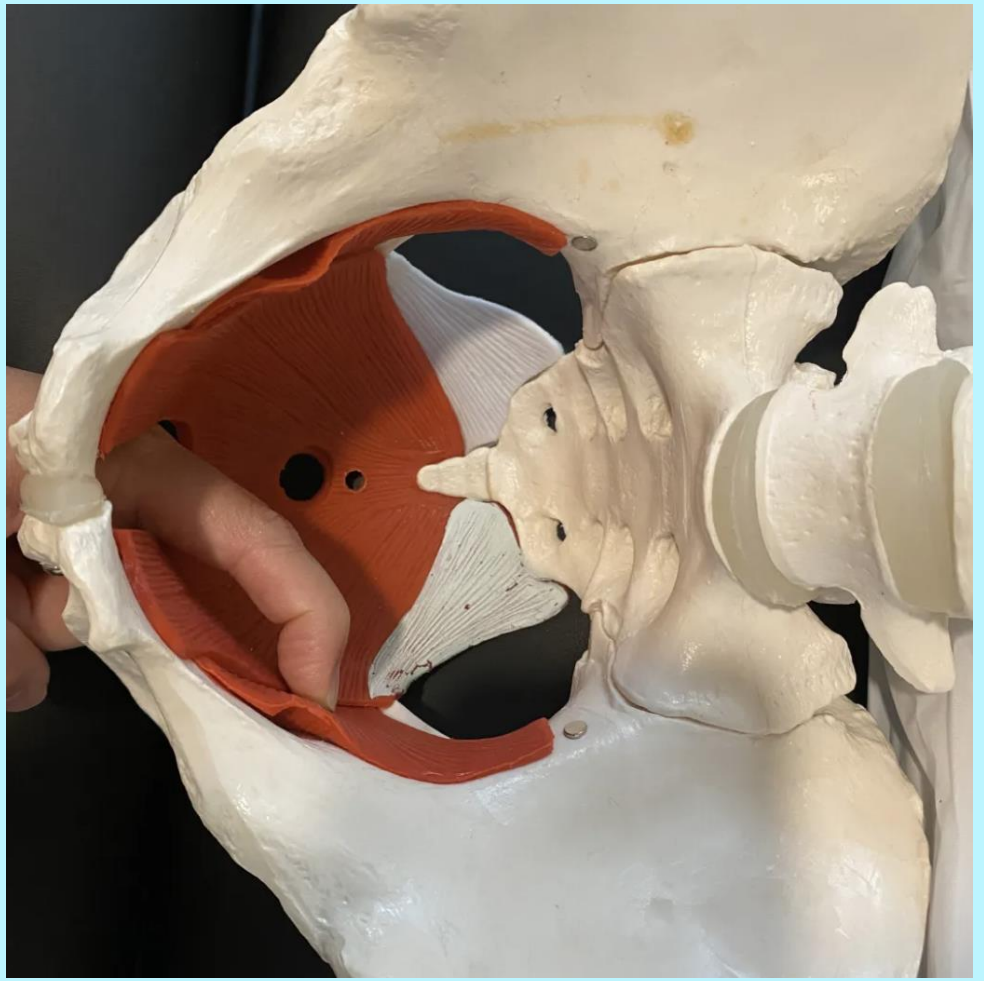
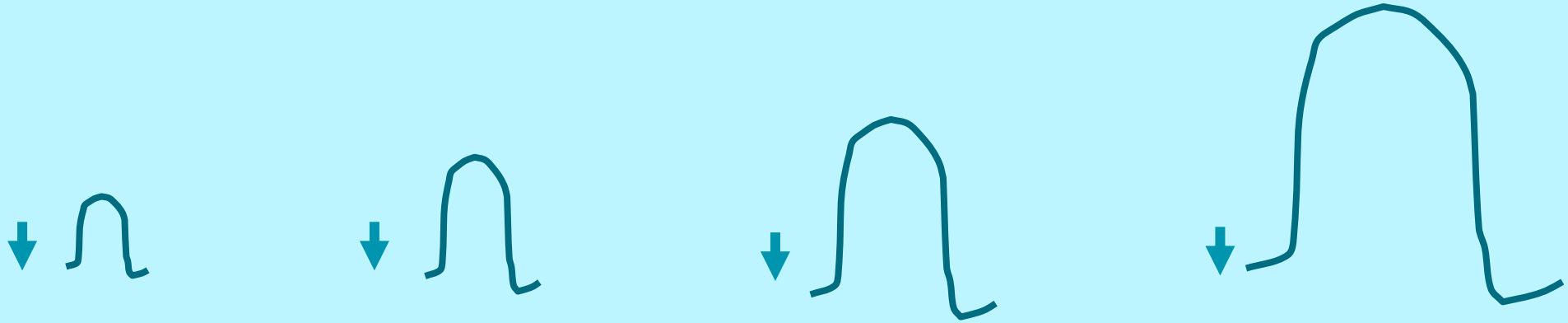
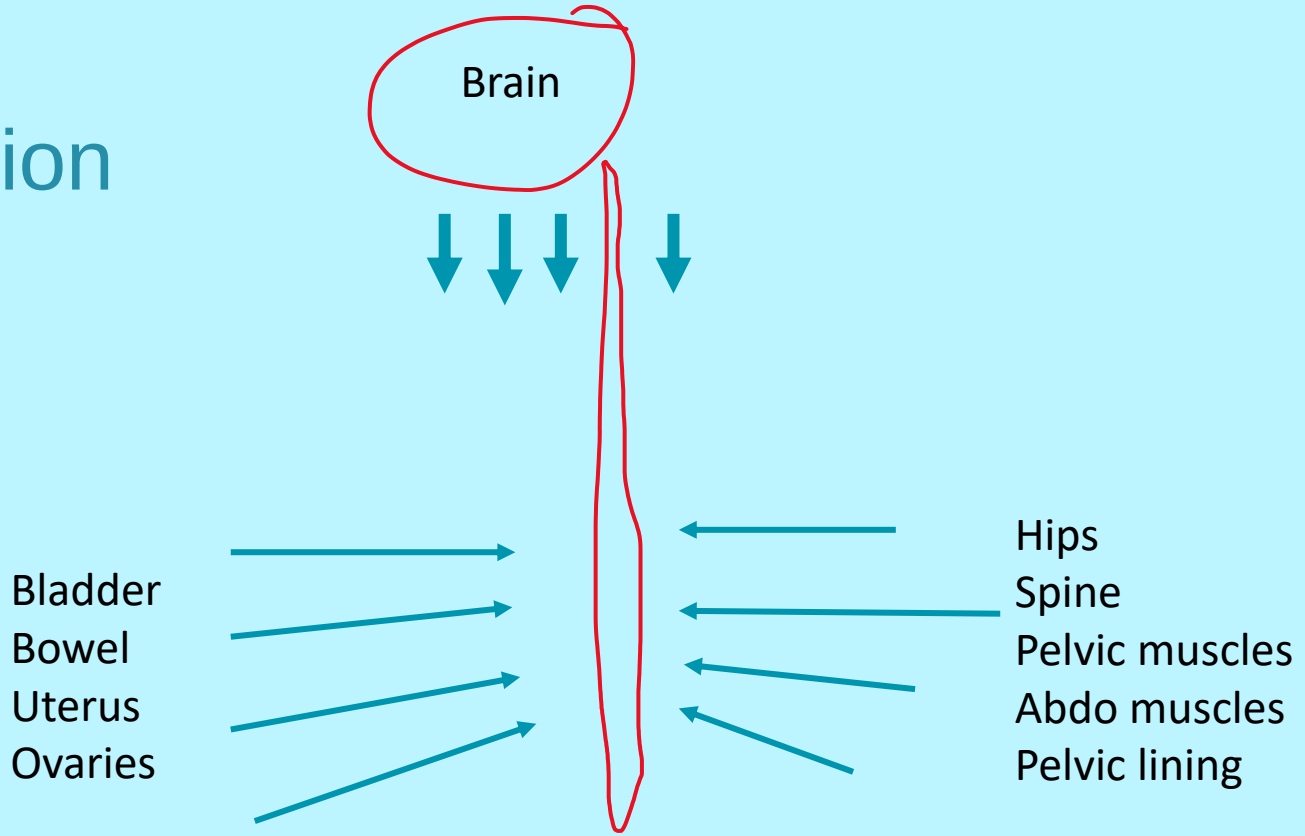




Discussing sensitisation



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 - endometriosis

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**

https://www.pelvicpain.org.au/wp-content/uploads/2022/11/Easy-Stretches-to-Relax-the-Pelvis-Stretches.pdf

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)
  - 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

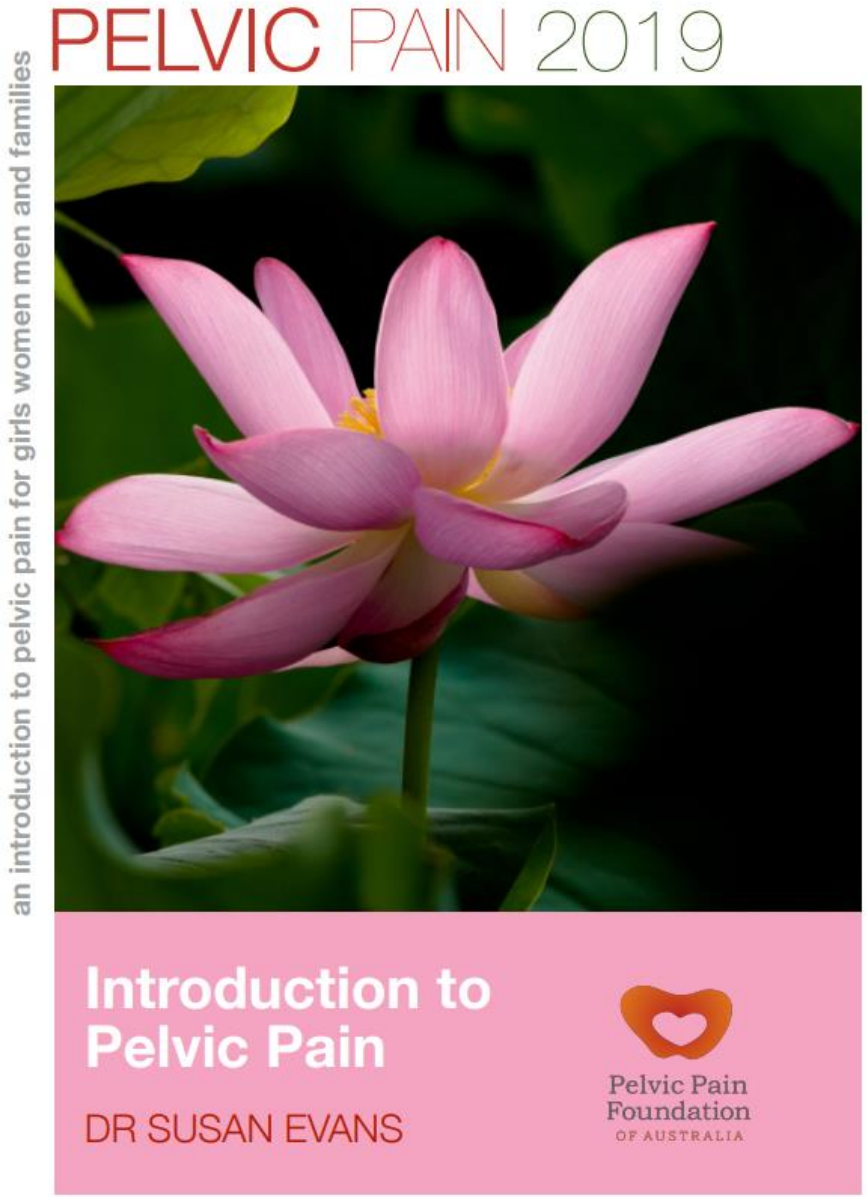
- Pelvic Pain - Australian Journal Of General Practice, Jan-Feb 2024 Vol 53, Issue 1-2 https://www1.racgp.org.au/ajgp/2024/january-february

- 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

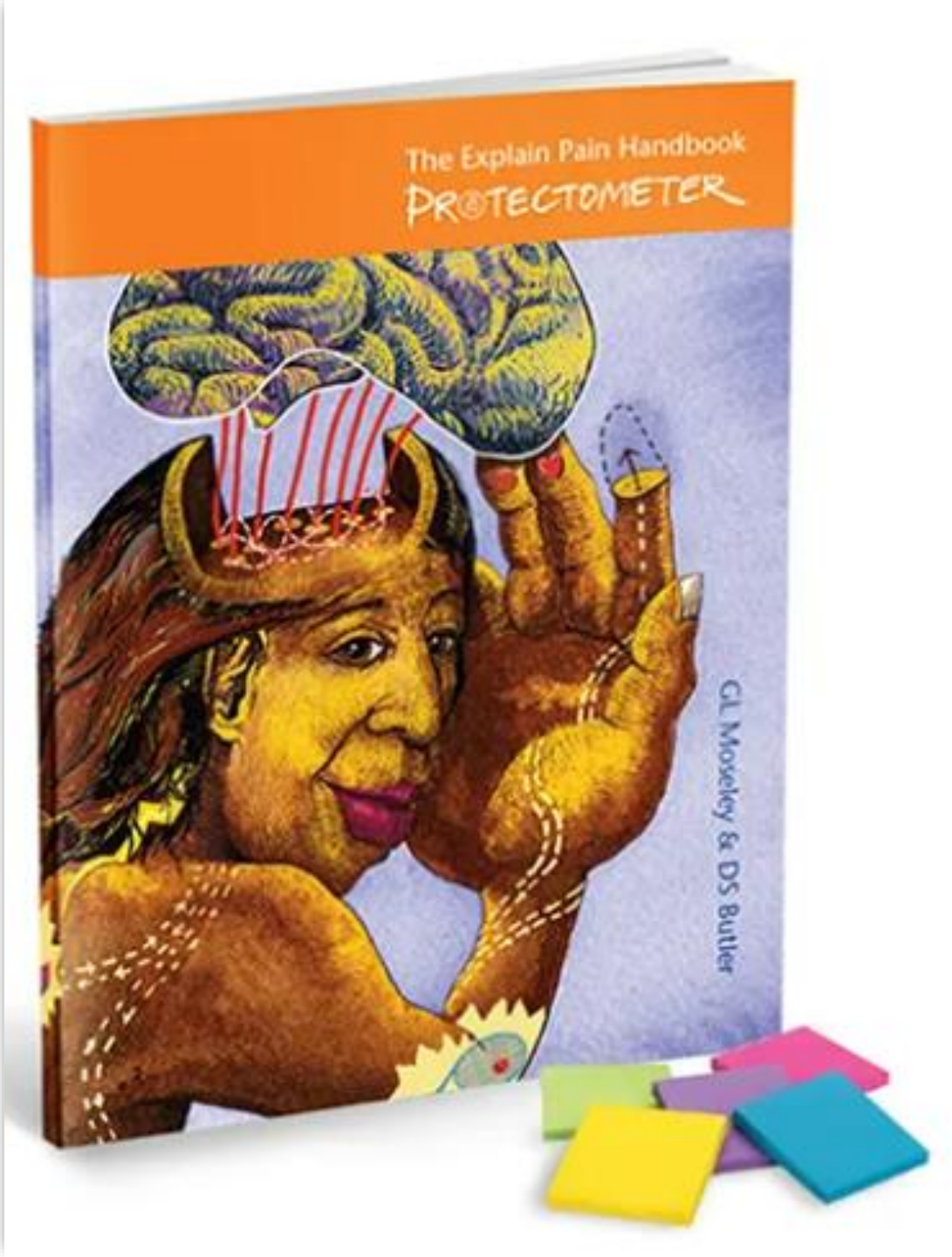
(10 pages but very complete assessment including activity levels, supports and mental health review)

Protectometer: The Explain Pain Handbook

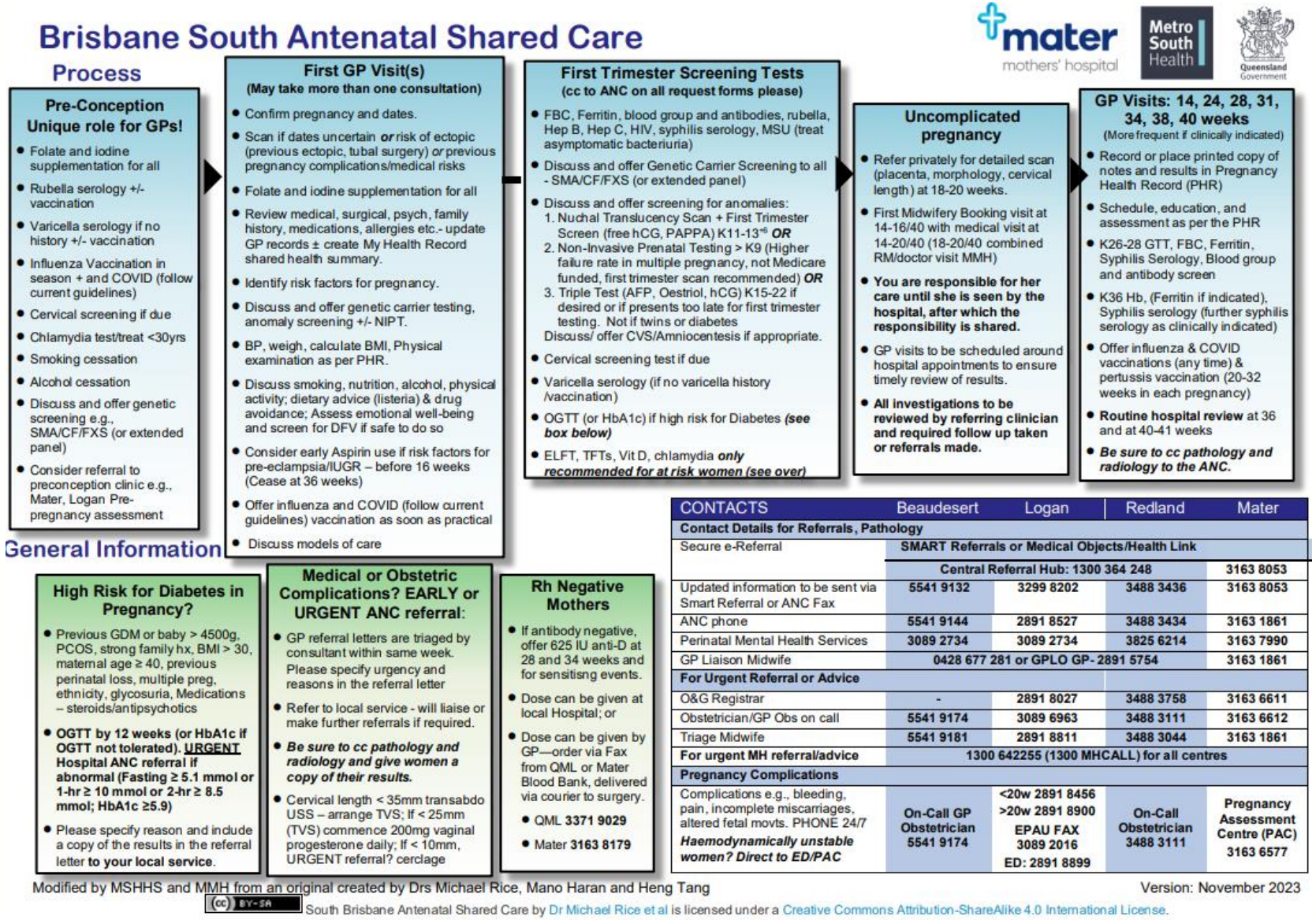
- The Explain Pain Handbook: Protectometer is for anyone with persistent pain, who wants to understand the latest ideas in neuroimmune pain science – and use that knowledge to reduce their pain. Not just a book to read and forget, but a workbook to think about, write in and work through. The Handbook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



Brisbane South Antenatal Shared Care Summary – November 2023



CONTACTS	Beaudesert	Logan	Redland	Mater
Contact Details for Referrals, Pathology				
Secure e-Referral	SMART Referrals or Medical Objects/Health Link			
	Central Referral Hub: 1300 364 248			3163 8053
Updated information to be sent via Smart Referral or ANC Fax	5541 9132	3299 8202	3488 3436	3163 8053
ANC phone	5541 9144	2891 8527	3488 3434	3163 1861
Perinatal Mental Health Services	3089 2734	3089 2734	3825 6214	3163 7990
GP Liaison Midwife	0428 677 281 or GPLO GP- 2891 5754			3163 1861
For Urgent Referral or Advice				
O&G Registrar	-	2891 8027	3488 3758	3163 6611
Obstetrician/GP Obs on call	5541 9174	3089 6963	3488 3111	3163 6612
Triage Midwife	5541 9181	2891 8811	3488 3044	3163 1861
For urgent MH referral/advice	1300 642255 (1300 MHCALL) for all centres			
Pregnancy Complications				
Complications e.g., bleeding, pain, incomplete miscarriages, altered fetal movts. PHONE 24/7 *Haemodynamically unstable women? Direct to ED/PAC*	On-Call GP Obstetrician 5541 9174	<20w 2891 8456 >20w 2891 8900 EPAU FAX 3089 2016 ED: 2891 8899	On-Call Obstetrician 3488 3111	Pregnancy Assessment Centre (PAC) 3163 6577

Modified by MSHHS and MMH from an original created by Drs Michael Rice, Mano Haran and Heng Tang

Version: November 2023

Available at [GP Maternity Share Care Education Event](#) webpage

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

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 or women with hypertension or known or suspected renal or liver disease.
- Routine TFTs *are not* recommended in low-risk women during pregnancy. 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 who have 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. Re-test after 3 months.
- Toxoplasma, cytomegalovirus, and herpes serology should *not* be performed routinely. If there is a risk factor indicating a need for testing, please include it in your referral as follow-up tests or other investigations or management may be needed.

Preventing Infections

- Avoid feeding raw/undercooked meats to pets, avoid cat faeces/litter, wear gloves when gardening.
- 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)
- Avoid soft cheeses, un-pasteurised milk, pate, raw eggs, hot dogs, undercooked and deli meats, reheated leftovers, precut fruit, bean sprouts.

Nutrition and Supplements

- Folate, folate, folate! 0.5 mg for all low risk, 5 mg for high risk (diabetic, obese, previous, or familial neural tube defect, anticonvulsants). Start a month before conception and continue to 12 weeks.
- Iodine 150mcg/day is recommended preconception, during pregnancy and while breastfeeding and a folate + iodine supplement is available. Multivitamins are optional, if chosen, pregnancy/breastfeeding formulas are preferred as they contain iodine and folate, but no Vit A. Iron is only needed if deficiency is identified however a low dose is included in all pregnancy supplements.
- Added supplements needed for women post Bariatric Surgery – seek Dietitian input.
- Avoid or limit the intake of large/predatory fish due to their mercury content (Orange Roughy /Sea Perch, Shark/Flake, Swordfish, Marlin etc.)

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 EPAU 2891 8456 Redland 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 to ANC by Fax
- Perceived change in fetal movements beyond 28 weeks or no FH detected – arrange IMMEDIATE hospital review.
- Most should be referred to birth suites, pregnancy/maternity assessment/observation units or emergency department at booking hospital.

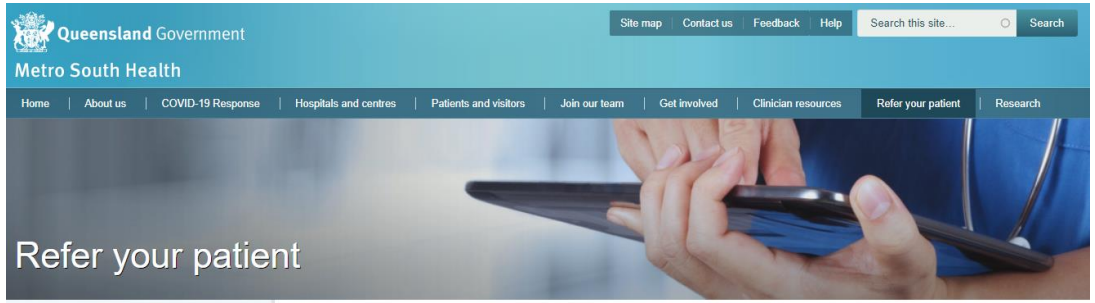
Beaudesert 5541 9111 Logan MAC 2891 8811 Redlands 3488 3111 Mater PAC 3163 6577

More Information and education

Online education/information 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)
- Maternity Shared Care workshops will be promoted via the Brisbane South PHN website events calendar https://bsphn.org.au/support/workforce-development-education/calendar/
- www.maternity-matters.com.au has consumer and clinician resources and links to reputable websites

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 – Nov 2023
www.materonline.org.au | www.https://metrosouth.health.qld.gov.au/referrals/general-practice-liaison-officer-gplo-program



Home > Refer your patient > General Practice Liaison Officer (GPLO) Program

General Practice Liaison Officer (GPLO) Program

Metro South GPLO Team are here to assist

The GP Liaison Officers (GPLO's) are available to support and assist GP's with:

- face to face, phone or email support
- providing information and guidance on referral pathways and navigating Metro South Health services including Refer Your patient – Metro South Health and SpotOnHealth HealthPathways
- assistance with GP Smart referrals - training support and troubleshooting
- supporting clinical handover between primary and secondary care, including assistance with updating your practice details in the STS address book for electronic communication and secure messaging
- being an escalation point and communication pathway for feedback.
- assistance with registration to the Health Provider Portal to gain read-only online access to your patients' Queensland Health (QH) records

Contact details:

Email: GPLO_Programs2@health.qld.gov.au
Telephone: 1300 364 155 (option 2) Mon-Fri 8am-4pm

General Practice Liaison Officer (GPLO) Program Metro South Health

GPLO Maternity Shared Care Team Metro South

The Metro South GPLO Maternity Shared Care team are based at Logan Hospital, but work liaising between Metro South Maternity services and GPs across the hospital catchments. The team comprises of GP Liaison Dr Kim Nolan, a highly experienced women's health specialist GP and GP Liaison Midwife Manager Lisa Miller. The team are available to assist with patient queries, referrals, patient handover, and to liaise with the obstetric team on your behalf. We currently run several GP Alignment Education events each year which are designed to assist GPs in providing high level maternity shared care within Metro South.

Latest event

- **Saturday 11 November 2023**: Metro South GP Maternity Shared Care Alignment 1 - Logan/Beaudesert/Redland

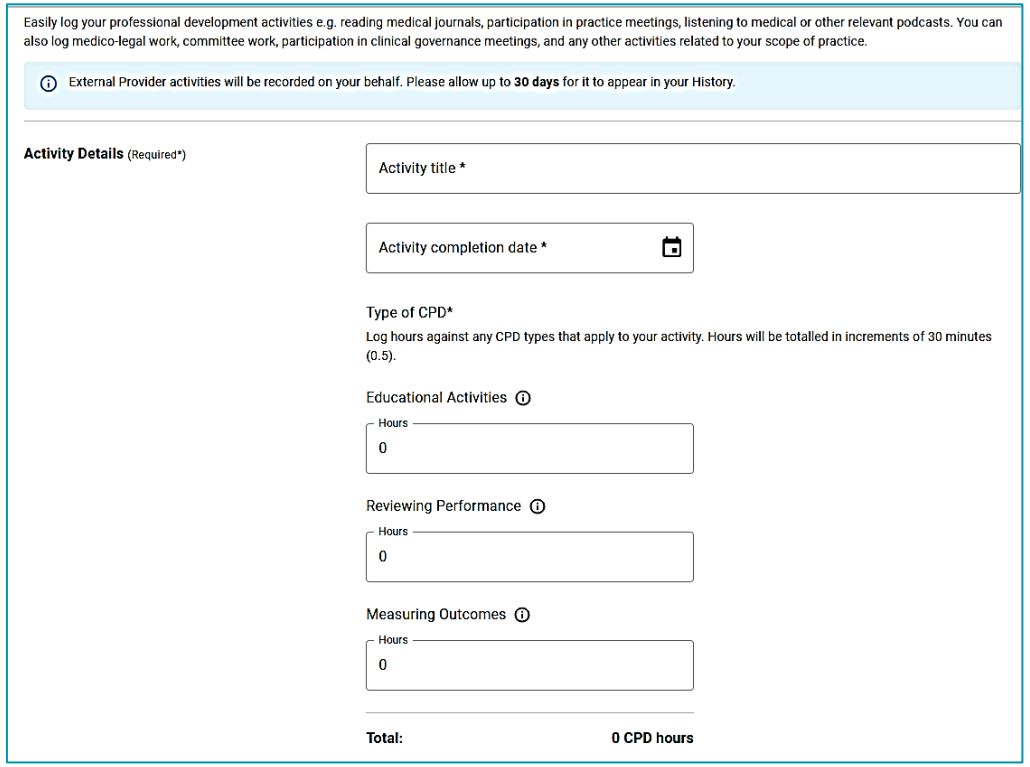
Contact details

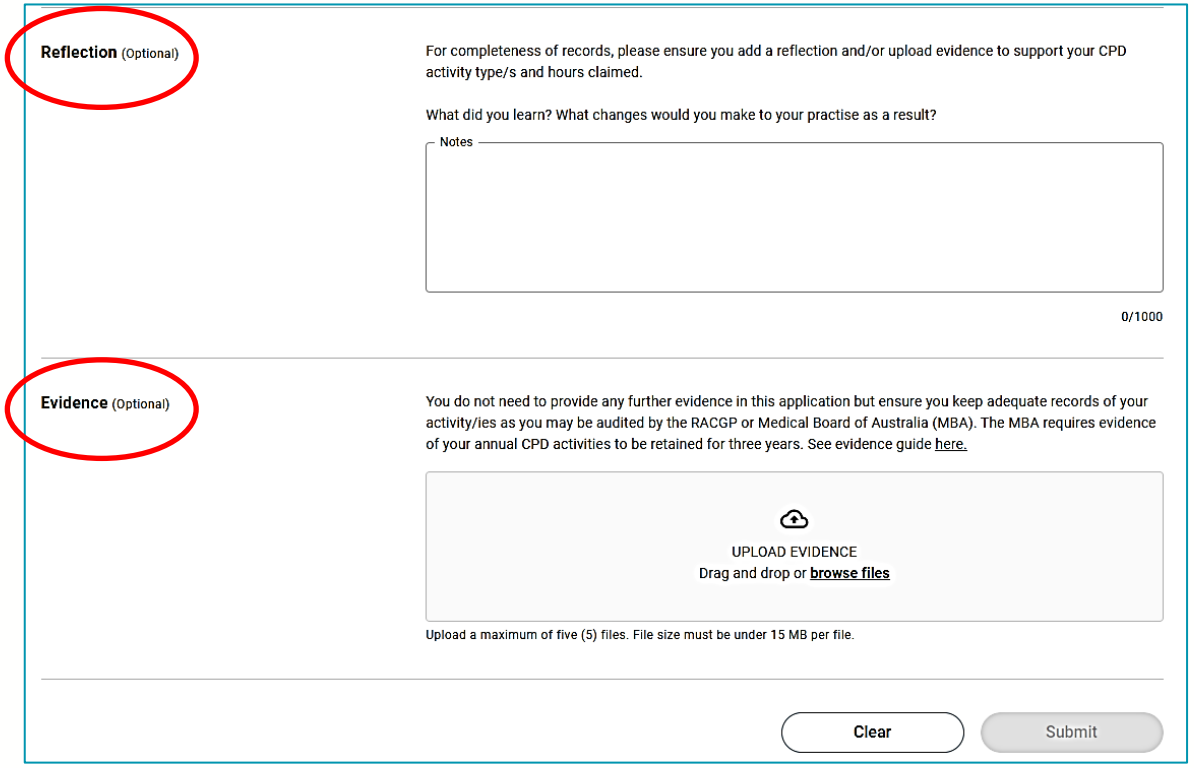
Dr Kim Nolan
M.B.B.S; DRANZCOG; FRACGP; DCH
GPLO General Practitioner – Maternity
Obstetrics and Gynaecology Department
Logan Hospital
Phone: 07 2891 5754
Email: Kim.Nolan@health.qld.gov.au

Lisa Miller
General Practice Liaison Midwife Manager
Women's & Children's Services | Logan Bayside Health Network
Logan Hospital
Phone: 0482 677 946
Email: Lisa.Miller3@health.qld.gov.au

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!
- Please log your own CPD points – recommended as Educational Activity CPD points (6 hrs) and Reviewing Performance Points (1.5-2 hrs)
- 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.





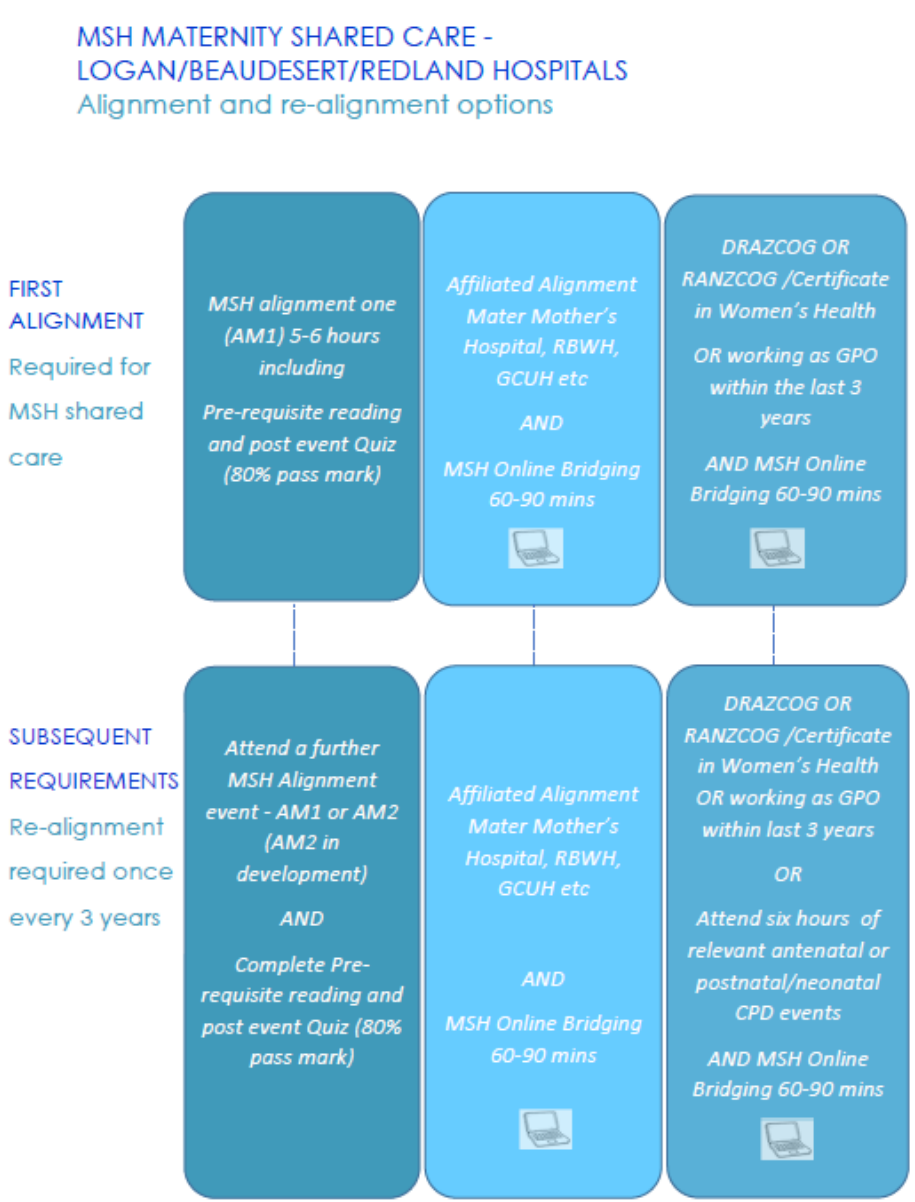
For GPs who hold DRANZCOG (now RANZCOG Associate) Qualifications – From 1st January 2024, when completing your mandatory Professional Development Plan (PDP) with your College CPD program, you are required to include goal(s)/activity(s) for women's reproductive health and provide evidence of completion 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 self-reporting of CPD points - Reviewing Performance Gynae GP Education Day - Sat 2nd March 2024

Red Case – Task 1	**Green Case – Task 1**	**Pink Case – Task 1**
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

Next MSHHS MATERNITY ALIGNMENT Saturday 20th April 2024 at this venue

- 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

AM2 planned for mid-year – Preconception and Postnatal Care (including Lactation Consultant and neonatal common conditions – Paediatrician)

MSH Maternity Shared Care Online Bridging Programme

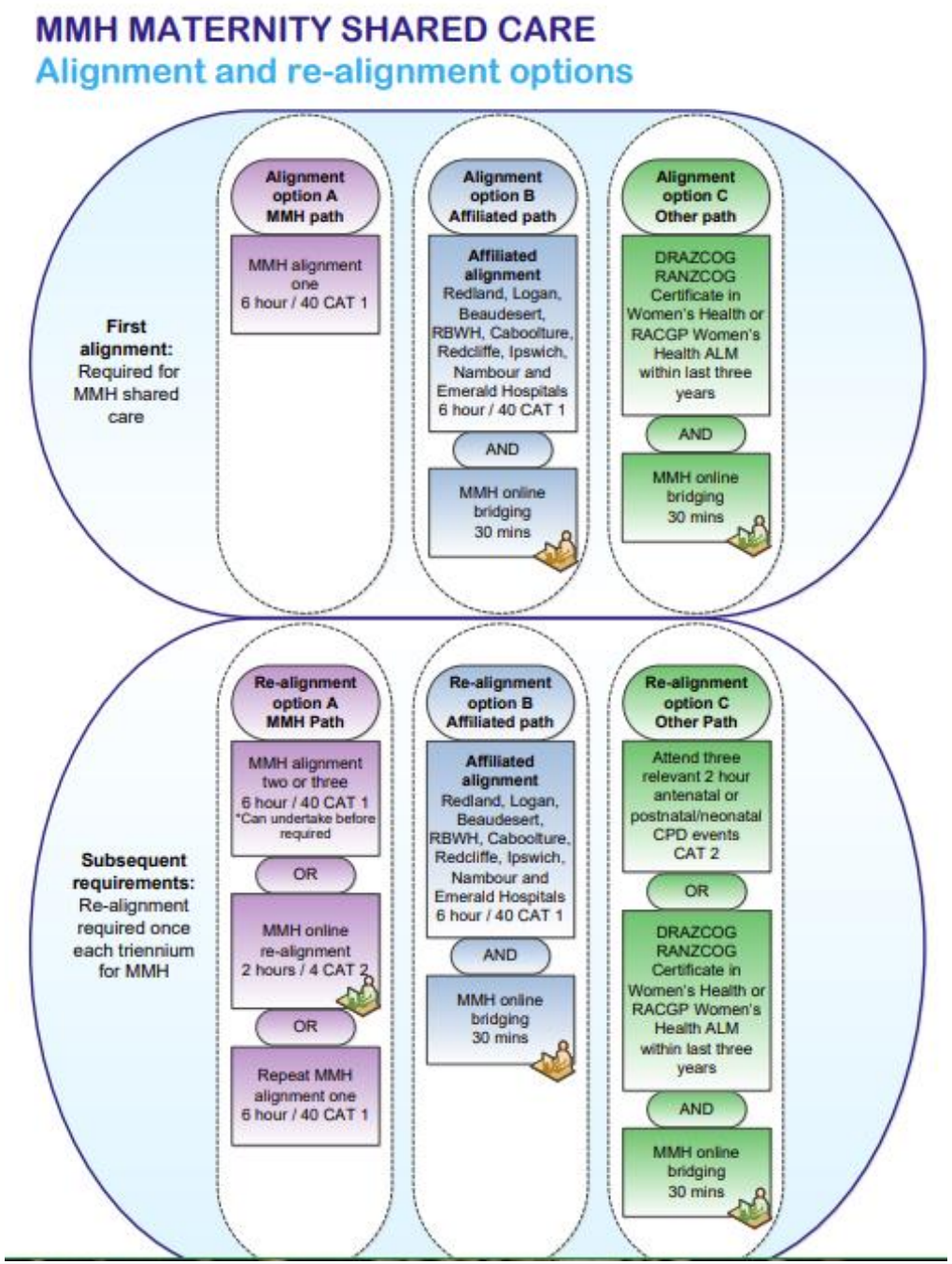
- Programme is delivered via an interactive online learning module including an exam/quiz to complete.
- Available to GPs who are currently aligned to Shared Care at MMH (or an alternative SEQ Alignment) and wish to align with MSH.
- Takes approximately 1- 1 ½ hours to complete.
- Once complete, GPs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

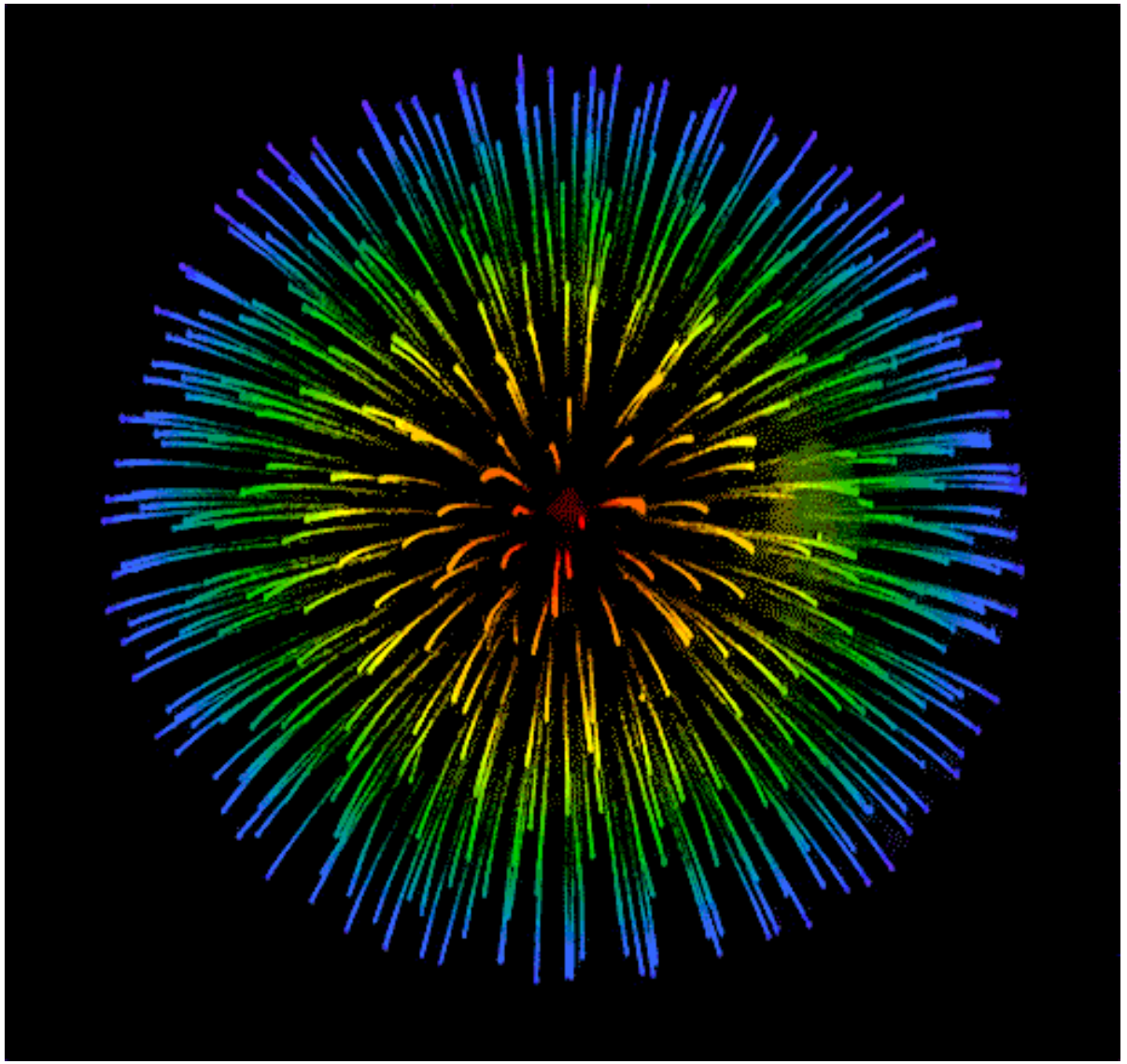
MMH Alignment

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

OR

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





Enjoy the remainder of your weekend!