Monash Health Referral Guidelines
GYNAECOLOGY

EXCLUSIONS

Services not offered by Monash Health

In Vitro Fertilisation

CONDITIONS

Paediatric and Adolescent Gynaecology

Chronic Pelvic Pain

CONTRACEPTIVE COUNSELLING
Sterilisation
Intra Uterine Device (IUD)
Implanon
Terminations of pregnancy

DYSPLASIA
Abnormal pap tests
Vulval ulcers
Vulval disorders
Genital warts

Endometriosis

GYNAECOLOGY ENDOSCOPY
Ovarian Cysts
Dyspareunia
Fibroids
Pelvic Inflammatory disease

GYNAECOLOGY ONCOLOGY
Cancer of the cervix
Ovarian cancer
Gynae cancers - suspected and confirmed

MENOPAUSE
Turner 's Syndrome
Cancer and menopause
Premature menopause
General menopause

MENSTRUAL MANAGEMENT
Abnormal menstruation
Uterine problems
Cervical polyps
Vulval Cysts
Bartholin's cysts / vaginal lesions
Post menopausal bleeding
Post coital bleeding

PELVIC FLOOR/UROGYNAECOLOGY
Vaginal Prolapse
Incontinence
Urodynamics

REPRODUCTIVE MEDICINE
Infertility
Amenorrhea
Recurrent miscarriages
Tubal & vasectomy reversal
Endocrine problems (Polycystic Ovarian Syndrome)

SEXUAL MEDICINE & THERAPY CLINIC
Sexual & relationship counselling

Head of unit: Professor Beverley Vollenhoven
Program Director: Professor Ryan Hodges
Last updated: 23/4/2018

Monash Health Referral Guidelines
GYNAECOLOGY

PRIORITY

All referrals received are triaged by **Monash Health clinicians** to determine **urgency of referral.**

EMERGENCY

For emergency cases please do any of the following:
- send the patient to the Emergency department OR
- Contact the on call registrar OR
- Phone 000 to arrange immediate transfer to ED

URGENT

The patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly.

ROUTINE

The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

REFERRAL

How to refer to Monash Health

Mandatory referral content

Demographic:
Full name
Date of birth
Next of kin
Postal address
Contact number(s)
Email address
Medicare number
Referring GP details
including **provider number**
Usual GP (if different)
Interpreter requirements

Clinical:
Reason for referral
Duration of symptoms
Management to date and response to treatment
Past medical history
Current medications and medication history if relevant
Functional status
Psychosocial history
Dietary status
Family history
Diagnostics as per referral guidelines

Click here to download the outpatient referral form

CONTACT US

Medical practitioners

To discuss complex & urgent referrals contact the on call registrar at Monash Medical Centre on 9594 6666:

1. Gynae-oncology registrar or
2. Gynaecology registrar

General enquiries

Phone: 1300 342 273

Submit a fax referral

Fax referral form to Specialist Consulting Services: 9554 2273

Head of unit: Professor Beverley Vollenhoven

Program Director: Professor Ryan Hodges

Last updated: 23/4/2018

PAEDIATRIC AND ADOLESCENT GYNAECOLOGY

Patient Presentation

Any gynaecological problem in a girl aged <18.

Most often this includes problems with their periods, including primary or secondary amenorrhea, dysmenorrhea, menorrhagia, delay or abnormal development of secondary sexual characteristics or ovarian cysts. However, any gynaecological problem in the <18 age group may be referred.

Initial GP Work Up

Depends on the presentation. Can include

- Ultrasound of the pelvis
- Bloods: LH, FSH. TFTs. bHCG, PRL. E2
- If menorrhagia: FBE, iron studies, TSH
- If signs of increased androgen DHEAS, FAI, SHBG , total testosterone
- If ovarian cysts then consider the tumour markers, most importantly Ca125

Management Options for GP

N/A

WHEN TO REFER?

Routine

- Any abnormality on the tests
- For management of troublesome irregular periods, especially when fewer than 6 periods per year.
- Significant menorrhagia with drop in Hb<100
- Primary amenorrhea
- Secondary amenorrhea (>6 months)

BACK

CHRONIC PELVIC PAIN

Initial GP Work Up

Try to find out if gynaecological or bowel. Take a history on bowel habit to rule out constipation as a cause. Try to illicit if irritable bowel syndrome is the problem

Management Options for GP

Pelvic Ultrasound

WHEN TO REFER?

Routine

If diagnosis is uncertain

BACK

CONTRACEPTIVE COUNSELLING

- Sterilisation
- Intra Uterine Device
- Implanon
- Termination of pregnancy

Initial GP Work Up

Termination of pregnancy: if dates uncertain, pelvic ultrasound

Management Options for GP

N/A

WHEN TO REFER?

Routine

For procedure or insertion

BACK

DYSPLASIA

CONDITION: ABNORMAL PAP SMEAR

Initial GP Work Up

- An up to date cervical screening test (CST)
- Consider using Oestrogen cream in post-menopausal patients
- STI screen and vaginal/cervical
- swabs where appropriate
- History of previous abnormal results
- Sexual history/recent change of partner
- HPV vaccination history
- History of IMB,PCB,PMB or watery discharge

Management Options for GP

- Repeat CST as per Guidelines for the Management of Asymptomatic women with screen detected abnormalities
- Consider using Oestrogen cream in post-menopausal patients
- Ultrasound in cases of PMB, IMB
- Pap smear in all cases of PMB
- Exclude and treat STI's

WHEN TO REFER?

Emergency

In cases of frank malignancy ring the Gynae-Oncology Unit

Urgent

Urgent referral for pregnant patients, a suspicious cervix i.e. appearance of malignancy, results requiring colposcopy. PCB in the older woman i.e. 40 yrs.

BACK

CONDITION: VULVAL ULCERS

Initial GP Work Up

- History of itching/age of patient and onset of symptoms
- History of chronic itching
- Sexual history
- History of drug use or recent change of medication.
- History of chronic conditions such as Chrohns Disease
- Does the ulcer appear infective or non-infective?

Management Options for GP

- Swab the ulcer to exclude infective cause
- Swabs for STI screen
- Bloods for serology as appropriate i.e. Syphilis
- Treat systemic symptoms such as fever, dysuria and pain
- Exclude UTI
- Use of bland emollients such as Zinc/Castor oil cream
- Treat Herpes Simplex with appropriate anti-virals. Hospitalisation may be needed if unable to urinate

WHEN TO REFER?

Urgent

Urgent referral for ulcers in menopausal patients, any ulcer that has not responded to a short course of emollients or a mild steroid cream

BACK

DYSPLASIA (cont'd)

CONDITION: VULVAL DISORDERS

WHEN TO REFER?

Initial GP Work Up

- History of complaint
- Associated factors i.e. Candida
- Age of patient
- Symptoms of discharge or systemic illness, chronic disease
- Presence of extensive leukoplakia

Urgent

Urgent referral for ulceration or a patient unresponsive to a short course of mild cortisone cream, menopausal patients with a history of chronic itching, a patient with a co-existent abnormal pap smear or when Lichen Sclerosus is suspected

Management Options for GP

- Swabs
- General blood tests i.e. FBE
- Use of mild topical cortisone cream for a short period may be appropriate
- Treat candida-vaginally and topically
- Avoid soap and shower gels

BACK

CONDITION: GENITAL WARTS

WHEN TO REFER?

Initial GP Work Up

- History of appearance
- Sexual; history, change of partner
- CST history
- History of smoking/immunosuppression

Urgent

Urgent referral for extensive genital warts or warts unresponsive to a short course of local treatment, warts present in vagina or on cervix

Management Options for GP

- CST
- STI screen
- Counselling
- Use of topical agents such as Aldara or Podophyllinrat

BACK

ENDOMETRIOSIS

WHEN TO REFER?

Patient Presentation

Pelvic pain with symptoms suggestive of endometriosis

Routine

For diagnosis and management

Initial GP Work Up

Pelvic ultrasound

Management Options for GP

Refer

BACK

GYNAECOLOGY ENDOSCOPY

CONDITION: OVARIAN CYSTS

WHEN TO REFER?

Initial GP Work Up

History

- Asymptomatic?
- Incidental clinical or ultrasound finding
- Symptomatic?
- Cyclical symptoms
- Pain
- Dyspareunia
- Irregular cycle
- Gastrointestinal
- Note: Ovarian pathology (e.g. torsion and not least carcinoma) may present with gastrointestinal symptoms.
- Risk of malignancy greater pre-pubertally and with increasing age to 70+/-)

Investigations

(a) examination

- Size
- Consistency
- Contour

(b) Ultrasound scan
(specialist experienced in Gynaecological Ultrasound)
(c) Tumour Markers (CA 125, Ca 19.3, AFP, CEA, hCG, LDH, Inhibin) ROMA test

Management Options for GP

- If 5cm+/- size. Repeat scan after menstrual period when applicable (can exclude such as corpus luteal cysts)
- Was the ultrasound both transvaginal and abdominal? Ultrasound should comment as to whether the cyst has any malignant features such as: Septae, solid areas, papillary projections, ascites or abnormal blood flow.

Urgent
Symptomatic: Refer urgently if persistent or colicky pain, weight loss, anaemia, any suspicion of ascites or irregularly contoured mass on abdominal or pelvic examination

Routine
Asymptomatic: Refer as soon as possible

BACK

CONDITION: DYSPAREUNIA, FIBROIDS

WHEN TO REFER?

Initial GP Work Up

Dyspareunia: Superficial or Deep

- If superficial consider vaginismus and referral to Sexual Medicine and Therapy clinic (previously SARC)
- Ultrasound if deep

Fibroids

- Ultrasound

Management Options for GP

Dyspareunia: If superficial make sure that patient does not have a vaginal infection especially if recent onset

Fibroids: Nil

Routine
Asymptomatic: Refer as soon as possible

BACK

GYNAECOLOGY ENDOSCOPY (Cont'd)

CONDITION: ACUTE PELVIC INFLAMMATORY DISEASE

WHEN TO REFER?

Urgent

Positive pregnancy test with pelvic pain +/- fever (consider abortion). Refer for admission

Acutely unwell, pelvic mass, unresponsive to treatment (12-16 hours)

Initial GP Work Up

- Symptomatology - pain, discharge, pyrexia
- Out of phase bleeding
- ? presence of IUCD

Investigations

- FBE/ESR
- HVS/Chlamydia smear/swabs
- Urine specimen -Chlamydia
- Endocx/urethra l/rectal swab
- HCG
- ?Smear

Management Options for GP

Antibiotics for PIDs.

Triple therapy:

- Augmentin 500mgs TDS 10 days
- Flagyl 400mgs TDS 7 days
- Doxycycline 100mgs BID minimum 14 days

Link and liaise with STI clinic as appropriate

(Note: Erythromycin may be used as an alternative to Augmentin in cases of penicillin allergy)

BACK

CONDITION: CHRONIC PELVIC INFLAMMATORY DISEASE

WHEN TO REFER?

Routine

Chronic PIO: Unresponsive to treatment

Initial GP Work Up

Symptomatology _ chronic pain, discharge, erratic bleeding, recurrent episodes of acute PIO, dyspareunia

Investigations

- See acute
- Ultrasound scan

Management Options for GP

Symptomatic after treatment - refer

BACK

GYNAECOLOGY ONCOLOGY

CONDITION: CANCER OF THE CERVIX:

Initial GP Work Up

- FBE, UEC if bleeding
- CST

WHEN TO REFER?

Urgent
Contact the Gynae-Oncology Unit

CONDITION: OVARIAN CANCER:

Initial GP Work Up

- CA125, CA19.9, CEA
- Other tumor markers as per gynaeoncology team. ROMA test
- Pelvic USS+/- CT (C/A/P)
- FBE, UEC

CONDITION: GYNAE CANCERS -SUSPECTED AND CONFIRMED

Initial GP Work Up

- FBE, UEC
- Pelvic USS+/- CT
- CST

Management Options for GP

Refer to gynaeoncology

BACK

MENOPAUSE

CONDITION: TURNER'S SYNDROME

Initial GP Work Up

Previous information re history and diagnosis of Turner's Syndrome, ongoing management details including hormone therapy and results

WHEN TO REFER?

Routine
When is in transition from paediatric to adult long term follow up. New hormone therapy issues.

Management Options for GP

- Refer to Adult Turner's Syndrome Long term Care Clinic
- (First Thursday March, June, September and December)

BACK

CONDITION: MENOPAUSE AFTER CANCER, MENOPAUSE AFTER RISK REDUCTION SURGERY.

Initial GP Work Up

Information of diagnosis, management and therapy of cancer

WHEN TO REFER?

Routine
With onset of symptoms of menopause or prior to risk reduction surgery

Management Options for GP

Refer to Menopause after cancer clinic

BACK

CONDITION: PREMATURE MENOPAUSE, SURGICAL MENOPAUSE

Initial GP Work Up

Two FSH/E2 levels at least 1 month apart if spontaneous menopause

WHEN TO REFER?

Routine
With elevated FSH / symptoms of menopause under the age of 45 if spontaneous menopause. Preferably prior to surgery.

Management Options for GP

Refer Early Menopause Clinic

BACK

MENOPAUSE (Cont'd)

CONDITION: MENOPAUSAL PROBLEMS WITH COMPLEX MEDICAL OR SURGERY PROBLEMS OR GENERAL MENOPAUSE

WHEN TO REFER?

Initial GP Work Up

Information about medical or surgical history

Management Options for GP

Refer to Menopause Clinic

BACK

MENSTRUAL MANAGEMENT

CONDITION

- Abnormal menstruation – excessive irregular menstrual loss (minimum of 3 months unless bleeding continues)
- Uterine problems
- Cervical polyps
- Vulval cysts

WHEN TO REFER?

Urgent

Anaemia Hb < 80 g/l

Routine

Age > 37, Pelvic mass, Abnormal smear, Non response to other treatment modalities

Initial GP Work Up

- Drug History
- Symptomatology, e.g. pain, fatigue,
- Family / personal history of haematological disorders
- Evidence of any genital tract abnormalities / abdominal mass
- Sexual history
- Ability to cope with bleeding, e.g. time off work

Investigations

- FBE / iron studies
- Thyroid function test
- CST
- Pelvic ultrasound (especially if clinically undiagnosable pelvic mass)
- Pregnancy test

Management Options for GP

- Hormonal control, e.g. oral contraceptive /HRT
- Non steroidals, e.g. Mefenamic Acid 500 mgs TDS
- Treat anaemia (Hb<80g/l and low iron studies) for a minimum of 3 months
- Dietary advice
- Manage other abnormal investigations, e.g. hypo / hyper thyroidism

BACK

MENSTRUAL MANAGEMENT (Cont'd)

CONDITION: BARTHOLIN'S CYSTS / VAGINAL LESIONS

WHEN TO REFER?

Routine
For cyst management

Initial GP Work Up

- Antibiotic treatment of Bartholin's cyst is of no value.
- The older the patient and the more localised the lesion of the vulva, the more urgent the assessment.

Management Options for GP

- Bartholin's cyst, refer for specialist management
- Older women with localised lesion

BACK

CONDITION: POST COITAL BLEEDING

WHEN TO REFER?

Routine
Recurrent, troublesome or embarrassing – refer to specialist service

Initial GP Work Up

- Examine
- CST
- HVS

Management Options for GP

- Support and counselling
- Report further episodes
- Encourage return if symptoms recur / change

BACK

CONDITION: POST MENOPAUSAL BLEEDING (12 MONTHS FROM LAST MENSTRUAL PERIOD)

WHEN TO REFER?

Urgent
If endometrial thickness >10mm on ultrasound

Routine
Post-menopausal bleeding

Initial GP Work Up

- Drug history (contraception, HRT particularly oestrogen only regimens)
- Evidence of any genital tract abnormalities, e.g. cervical polyps / atrophic change or abdominal mass
- Sexual/ PIO history

Investigations

- CST
- HVS
- +/- pipelle
- Transvaginal Pelvic ultrasound
- Pregnancy test (unnecessary >55 years)

Management Options for GP

- Refer to specialist service – depending on ultrasound result
- Note: cervical polyps associated with post menopausal bleeding should be referred as frequently associated with sinister pathology

BACK

PELVIC FLOOR / UROGYNAECOLOGY

CONDITION: PELVIC ORGAN PROLAPSE (POP)

Initial GP Work Up

•History and examination
•Symptomatology – lump, “something coming down”, dragging discomfort, vaginal laxity, difficulty with defaecation / micturition, dyspareunia, voiding difficulty, urinary incontinence

Investigations
•MSU

Consider
•FBE
•Biochemistry
•Enal US (check post void residual)
•Pelvic US

Management Options for GP

Vaginal oestrogen in post menopausal. Offer trial of pelvic floor muscle training (this can be arranged at Monash Health also)

WHEN TO REFER?

Routine
Symptomatic prolapse

Note: For patients with mild-moderate POP symptoms, an appointment will be an Advanced Practice Physiotherapist for initial assessment and onward management (which may include consultation with/referral to medical team)

BACK

CONDITION: URINARY INCONTINENCE / VOIDING DIFFICULTY

Initial GP Work Up

- As for POP

Management Options for GP

- Offer Pelvic floor muscle training (can be arranged at Monash health)
- Consider trial of anticholinergic medication if predominantly urge or urge incontinence

WHEN TO REFER

Note: For patients with urinary incontinence an appointment will be with an Advanced Practice Physiotherapist for initial assessment and onward management (which may include consultation with/referral to the medical team)

BACK

CONDITION: RECURRENT UTIS

Initial GP Work Up

- MSU
- Renal and bladder US

Management Options for GP

- Vaginal estrogen
- Cranberry
- Hiprex and vit C
- Postcoital or low dose antibiotics

WHEN TO REFER?

Routine

- symptomatic or bothersome urinary or anal incontinence;
- symptomatic or bothersome urinary frequency, nocturia
- symptomatic or bothersome voiding difficulty, bladder pain,
- Recurrent Utis; haematuria

BACK

REPRODUCTIVE MEDICINE

CONDITION: INFERTILITY

WHEN TO REFER?

Routine
- If >12 months infertility and < 38 years of age
- If >6 months infertility and >38 years of age

Initial GP Work Up
- A thorough history and examination is required to determine a specific diagnosis and its degree of urgency. Some appropriate investigation by the referrer will facilitate the referral process
- Pelvic examinations – GPs, specialists

Management Options for GP
Specific treatments depend on specific problems identified as noted below (primary amenorrhoea, secondary amenorrhoea)

BACK

CONDITION: PRIMARY AMENORRHOEA

WHEN TO REFER

Routine
- Primary amenorrhoea – where there are abnormal results or significant patient stress / anxiety

Initial GP Work Up
- Age > 15
- Weight history
- Dietary history
- Exercise history
- Physical / secondary sexual development
- Family history
- Evidence of any congenital gynaecological abnormality /abdominal mass
- Sexual history

Investigations
- FSH/LH/HCG
- Prolactin x 3*
- Thyroid function test
- Ultrasound
- Chromosomal studies may be requested in consultation with the specialist service

Note: Only one is necessary if initial test is normal

Management Options for GP
Counselling and support

BACK

CONDITION: SECONDARY AMENORRHOEA (> 6 MONTHS)

WHEN TO REFER?

Routine
Secondary amenorrhoea – where there are abnormal results or significant patient stress / anxiety

Initial GP Work Up
- As for primary amenorrhoea
- Contraception history
- Drug history, e.g. psychtrophic
- Galactorrhea
- Signs of masculinisation
- Hirsutism
- Significant stress and anxiety
- Environmental factors
- Past gynaecological history / surgery

Investigations
- HCG
- FSH/LH/E2/Prolactin x3*
- Testosterone / SHBG / DHEA (if hirsute)

Management Options for GP
- Counselling and support

BACK

REPRODUCTIVE MEDICINE (Cont'd)

CONDITION: MALE INFERTILITY

Initial GP Work Up

- Semen analysis (preferably at specialist lab such as Monash IVF)

Management Options for GP

Lifestyle modification, in particular weight management, smoking and alcohol use

WHEN TO REFER?

Urgent
Immediately if no sperm present or severe changes on semen analysis

Routine
After 6 months of infertility

BACK

CONDITION: RECURRENT MISCARRIAGES

Initial GP Work Up

Careful general and obstetric history

Management Options for GP

Lifestyle modification, in particular weight management and smoking cessation.

WHEN TO REFER

Routine
Generally, following 3rd miscarriage. After 2 miscarriages if maternal age > 38 or if additional history of infertility

BACK

CONDITION: TUBAL & VASECTOMY REVERSAL

Initial GP Work Up

- Basic fertility check of other partner
- For tubal reversal
  - semen analysis
- For vasectomy reversal:
  - ovarian reserve: D2-5 AMH
  - confirmation of ovulation: D21progesterone

Management Options for GP

N/A

WHEN TO REFER

Routine
Refer as appropriate

BACK

CONDITION: ENDOCRINE PROBLEMS (POLYCYSTIC OVARIAN SYNDROME)

Initial GP Work Up

- TVUS
- OGTT
- FSH, LH, Prolactin, TSH
- Testosterone, SHBG, Free androgen index

Management Options for GP

- Lifestyle changes, in particular weight management
- OCP if not desiring pregnancy

WHEN TO REFER?

Routine

- For management of troublesome irregular periods, especially when fewer than 6 periods per year
- In the context of infertility

BACK

SEXUAL MEDICINE AND THERAPY CLINIC

SEXUAL & RELATIONSHIP COUNSELLING

Patient Presentation

We see patients (women, men and couples) with the following presenting complaints:

- An inability to have sexual intercourse
  - women with vaginismus or vulval pain syndromes
  - men with erectile dysfunction (psychogenic or mixed aetiology)
- Painful sex (dyspareunia)
- Lack of interest in, or desire for sex, which may lead to relationship difficulties.
- Arousal disorders
- Orgasmic or ejaculatory disorders (including PE)

We commonly see a mixed presentation of symptoms. We are happy to see individuals or couples.

We do NOT manage sexually transmitted infections.

Initial GP Work Up

For women with superficial dyspareunia (sexual pain):

- Assess for dermatological pathology and treat as appropriate or refer to vulval clinic or vulval dermatologist
- Assess for and treat infections or refer to Sexual Health Clinic such as Melbourne Sexual Health.

For deep dyspareunia

- Assess for (and treat) PIO or pelvic U/S where indicated. Refer to gynaecologist if Endometriosis is suspected.

For men with erectile dysfunction:

- A general metabolic workup: assess for Hypertension. Hyperlipidaemia, Diabetes and Testosterone levels

For lack of libido

- A general health assessment with history and general examination. Investigations as indicated.
- Assessment of psychological health and relationship factors.

Management Options for GP

For men with erectile dysfunction, possible trial of PDE51's once metabolic workup complete.

WHEN TO REFER?

Routine

- For assessment and management of any of the presenting problems (as above) if diagnosis or management is uncertain, or unsuccessful.
- Refer for management of Vaginismus
- When any sexual symptoms are having an impact on the relationship
- When patient is wanting to explore / discuss sexual concerns

BACK