Monash Health Referral Guidelines

(Incorporating Statewide Referral Criteria)

GYNAECOLOGY

EXCLUSIONS

Services not offered by Monash Health

In Vitro Fertilisation

CONDITIONS

CONTRACEPTIVE COUNSELLING

Contraception
Pregnancy Choices

SEXUAL AND REPRODUCTIVE HEALTH

DYSPLASIA

Dysplasia/Abnormal Cervical Screening Test
Vulval ulcers
Vulval disorders
Genital warts
Post-coital bleeding

GYNAECOLOGY ENDOSCOPY

Ovarian and other adnexal pathology
Dyspareunia
Pelvic Inflammatory disease
Persistent pelvic pain

PELVIC PAIN CLINIC

Requires Tertiary Referral

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

Persistent, heavy menstrual bleeding
Bartholin's cysts / vaginal lesions/Vulval cysts/nabothian cysts
Post-Menopausal bleeding
Persistent or unexplained intermenstrual bleeding
Fibroids
Recurrent Thrush
Endometrial/ Cervical polyps

PELVIC FLOOR/UROGYNAECOLOGY

Pelvic organ prolapse
Urinary incontinence
Recurrent UTI's
Rectovaginal fistula

REPRODUCTIVE MEDICINE

Infertility
Amenorrhea
Male infertility
Recurrent miscarriages
Tubal & vasectomy reversal
Endocrine problems (Polycystic Ovarian Syndrome)

SEXUAL MEDICINE & THERAPY CLINIC

Sexual & relationship counselling

PAEDIATRIC & ADOLESCENT GYNAE

Paediatric and Adolescent Gynaecology

ENDOMETRIOSIS

Endometriosis

Head of unit: Professor Beverley Vollenhoven
Program Director: Associate Professor Ryan Hodges
Last updated: 10/09/2021

Monash Health Referral Guidelines

(Incorporating Statewide Referral Criteria)

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: 9594 2273

For Termination of pregnancy phone call referral required please contact 9594 2457.

Head of unit: Professor Beverley Vollenhoven

Program Director: Associate Professor Ryan Hodges

Last updated: 10/09/2021

CONTRACEPTIVE COUNSELLING

CONTRACEPTION

WHEN TO REFER?

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Missing or lost strings on an intra-uterine device
- Request for tubal ligation
- Where hormonal contraception is contraindicated
- Where contraception is unable to be managed in primary care due to a complex medical condition (e.g. immunosuppression, breast cancer, multiple sclerosis, physical disability).

Routine

1For procedure or insertion of device

Information to be included in the referral

Information that **must** be provided

- Past gynaecological history including menstrual health and details of previous experience with contraception
- Relevant family history
- Relevant social Hx- eg Indigenous, mental health, disability, family violence, drug and alcohol addiction, refugees and CALD.

Provide if available

- Current cervical screening results
- Sexually transmitted infections test results

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Referrals should be made to suitable community-based services wherever possible (see 1800 My Options). Where a public health service also operates a community health service or GP clinic, demand for reproductive health services should be met through these GP clinics.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Note the statement on reversal of sterilisation in Victoria's *Elective Surgery Access Policy 2015*

Tubal Ligation

Reversal of tubal ligation requests go to the Reproductive Medicine Unit **(applies to Monash Health only).**

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Contraception andSterilisation

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions

CONTRACEPTIVE COUNSELLING (Cont'd)

PREGNANCY CHOICES

WHEN TO REFER?

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Surgical termination of pregnancy at later gestations
- Surgical termination of pregnancy where medical termination is no longer appropriate and services cannot be accessed outside of a public health service

Information to be included in the referral

Information that **must** be provided

- Results of human chorionic gonadotropin (hCG) confirming pregnancy
- Results of pelvic ultrasound confirming pregnancy and weeks of gestation
- Documented rhesus blood group

Provide if available
Not applicable

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Medical termination of pregnancy managed in primary care is preferred to surgical terminations where practicable.

Referrals should be made to suitable community-based services wherever possible (see 1800 My Options). A referral to a health service may be necessary if there is no suitable local community-based service available.

Providing surgical termination of pregnancy of later gestation requires specialist surgical staff and support services. Women who require this service should be directed to designated service providers.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Referral to a public hospital is not appropriate for

Not applicable

Urgent

Refer to Clinic on 9594 2457 (during working hours)

Continued over page

BACK

CONTACEPTIVE COUNSELLING (Cont'd)

PREGNANCY CHOICES (Continued)

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Termination of Pregnancy

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

Initial GP Work Up

- If dates are uncertain, provide pelvic ultrasound

Management Options for GP

Refer to Clinic: outpatient appointment is at Clinic D (Contraception Counselling Clinic, ph. 9594 2457) Monash Health 246 Clayton Road, Clayton Monday afternoon only.

• Procedures are done at Day Surgery Unit Moorabbin Hospital 823-865 Centre Road Bentleigh East on Friday afternoons only.

• Please let the patient know that they need to bring the following to their appointment:

○ Ultrasound report (if one has been done)

○ Medicare card

○ Proof of blood group if known (otherwise need blood grouping at Clinic)

○ Healthcare Card if eligible

○ $50 to cover medication (Misoprostal $7) and contraceptive Mirena and Implanon$40 ($7 with Healthcare card)

• N.B. Pharmacy does not take cash. If no credit card, need to use hospital cashier.

• Patients need to allow 2 hours for consultation with pharmacy wait time.

• Instructions for the pre op medications and details about the Friday procedure will be given at Clinic.

• There is no charge for the procedure of the general anaesthetic on Friday at Moorabbin.

• Car parking charges will apply. Concession for parking can be applied for at reception.

WHEN TO REFER?

BACK

DANDENONG SEXUAL HEALTH CLINIC

WHEN TO REFER?

1. **Catchment criteria**: Greater Dandenong area (this might be reviewed in future if funding changes)

2. **Conditions:**
- Gynaecological assessment
- Cervical screening & follow up
- Unplanned Pregnancy / fertility concerns
- Referral for STOP and MTOP
- Poly Gynaecological / Women's Health CONCERNS
- Sexual& General Health assessment
- Contraception Needs including Long Acting Contraception :
- Implanon Implants & IUD insertion & removal
- Sexually transmitted infection screening and Cystic Ovary Syndrome
- Endometriosis
- Abnormal Vaginal Bleeding / Menstrual concerns

3. **Target group:**
- Indigenous
- Mental Health
- Disability
- Youth UNDER AGE 25 (Dr request under 18 to be referred to adolescent clinic)
- Family Violence
- Drug & alcohol Addiction
- Refugee and CALD clients
- Financial & lack of access to services

DYSPLASIA

DYSPLASIA/ABNORMAL CERVICAL SCREENING TEST

WHEN TO REFER?

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Positive human papillomavirus, types 16 or 18, detected
- Positive human papillomavirus detected (but not types 16 or 18) and either;
  - possible or confirmed high-grade squamous intraepithelial lesions
  - ACIS and Glandular abnormalities.
  - gynaecology assessment recommended by cytology service.

Information to be included in the referral

Information that **must** be provided

- Current cervical screening results
- History of any abnormal bleeding or abnormal change
- If the woman has an immune-deficiency or is immunosuppressed
- If the woman is pregnant.

Provide if available
Not applicable.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Referral to a public hospital is not appropriate for;

In line with the cervical screening pathway If patient is asymptomatic and:

- human papillomavirus is not detected
- there are unsatisfactory liquid-based cytology or human papillomavirus testing
- possible, or confirmed, low-grade squamous intraepithelial lesions where human papillomavirus is not detected.

Continued over page

Emergency

Immediately contact the gynaecology registrar to arrange an urgent gynaecological assessment for:

- Visible suspicious cervical mass

In cases of frank malignancy ring the Gynae-Oncology Unit on 9594 6666

DYSPLASIA/ABNORMAL CERVICAL SCREENING TEST (Continued)

SEMPHN Pathways
Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Cervical Screening

HealthPathways
Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

Initial GP Work Up
- An up to date cervical screening test (CST)
- Or Co-test for symptomatic patients
- 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

Dysplasia Follow-up post LLETZ/Laser/Cone Biopsy: To be followed up by GP in 12 months. Not routinely for Dysplasia Clinic review.
Pt needs two consecutive normal 'test of cure' results taken yearly before returning to 5 yearly CST screening. Test of Cure CSTs are to continue yearly with GPs indefinitely for all ***HPV Non 16/18*** and ***low grade*** changes. Patients are to return to dysplasia clinic if test of cure results show ***HPV 16 or 18*** or ***high grade*** changes, are symptomatic or significantly anxious about results and request review.
Exceptions to this are requests for review from Gynae Oncology and may include
- Negative Histology on Cone Biopsy after HSIL LBC (ie Discrepant Results)
- All ACIS post-op
- Positive Endocervical Margins on Cone Biopsy/LLETZ

National Guideline changes for CST since February 2021:
- HPV Non 16/18 with LSIL/pLSIL/Negative Cytology: Repeat HPV test in 12 month, if the result is the same repeat the HPV again in 12 months. If still positive then re refer for colposcopy.
    - **Exclusion Criteria Includes HPV Non 16/18 with LSIL/pLSIL/Negative Cytology persistent at 12 months for :**
        - Age >50 yo
        - Aboriginal or Torres Strait Islander
        - Patient was overdue for testing by more than 2 years
        - Immunocompromised or Pregnant patient

Women who fall out of this recommendations with separate guidelines include:

- Test of Cure for post-op patients
- ACIS and DES follow up
- Women > 70 years (attending for exit test)

Patients with previous HPV Surveillance - If the comment from the cytopathologist reporting the smear recommends colposcopy then this should stand.

POST-COITAL BLEEDING

DHHS Statewide referral criteria apply for thiscondition

Criteria for referral to public hospital specialist clinicservices
• Unexplained recurrent post-coital bleeding.

Information to be included in the referralInformation that **must** be provided
• Findings from physical examination
• Transvaginal pelvic ultrasound results.
(Transabdominal pelvic ultrasound results can be provided for women who are a survivor of sexualassault or have declined a transvaginal pelvic ultrasound.)
• Past medical history (e.g. diabetes, polycystic ovarysyndrome)
• Results of recently conducted cervical screening
• Sexually transmitted infections test results.

Emergency

Direct to an emergency department that canprovide a gynaecology assessment:

- Acute, severe pelvic or abdominal pain
- Ectopic pregnancy
- Suspected torsion of ovary
- Suspected pelvic sepsis
- If the woman is haemodynamically unstable

Provide if availableNot applicable.

Additional comments
The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may bedirected to an alternative specialist clinic or service

Referral to a public hospital is not appropriate for:
Not applicable

SEMPHN Pathways
Please consult SEMPHN Pathways for assessment,management and referral guidance for this condition:

Postcoital bleedingHealthPathways
Please refer to HealthPathways Melbourne for guidance
in assessing, managing and referring for patientconditions (login required).

Initial GP Work Up
- Examine
- Co- Test
- HVS

Management Options for GP
- Support and counselling
- Encourage return if symptoms recur/ change
- If a single episode of PCB and cervix looks normal for GP to follow up patient.
- Post-menopausal women with PCB should be referred for colposcopy regardless of co-test result.
- Any patient with PCB and a positive HPV test regardless of LBC should have a colposcopy.

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

Persistent or recurrent vulval ulcers unresponsive to general measures should be referred. Refer all post-menopausal patients with vulval ulceration.

WHEN TO REFER?

Urgent Vulval ulceration

BACK

VULVAL DISORDERS

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

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

Vulval itching unresponsive to mild steroids and general hygiene measures should be referred regardless of age.

WHEN TO REFER?

DYSPLASIA (Cont'd)

GENITAL WARTS

WHEN TO REFER?

Initial GP Work Up

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

Management Options for GP

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

Refer patients with genital warts unresponsive to topical treatment or present around the anus.

BACK

GYNAECOLOGY ENDOSCOPY

OVARIAN AND OTHER ADNEXAL PATHOLOGY

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

• Suspected malignancy identified on clinical examination or imaging
• Pre-menopausal complex ovarian cyst, suspected endometrioma, or dermoid
• Persistent and enlarging ovarian cyst confirmed with imaging performed at least three months apart
• Symptomatic hydrosalpinx.

Information to be included in the referral

Information that **must** be provided
• Past medical history including pain and other symptoms
• Family history of breast and ovarian cancer
• Imaging results – Pelvic Ultrasound
• Cancer antigen 125 (CA 125) results if the woman is being referred for suspected malignancy or post-menopausal ovarian cyst.
• Tumour Markers (CA 125, Ca 19.3, AFP, CEA,hCG, LDH, Inhibin) ROMA test

Provide if available
Not applicable.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Referral to a public hospital is not appropriate for

Not applicable.

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Ovarian cyst pathway

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

Continued over page.

WHEN TO REFER?

Emergency

Direct to an emergency department that can provide a gynaecology assessment:

- Acute, severe pelvic or abdominal pain
- Ectopic pregnancy
- Suspected torsion of ovary
- Suspected pelvic sepsis
- If the woman is haemodynamically unstable

Urgent

- Suspected malignancy
- Symptomatic hydrosalpinx

BACK

GYNAECOLOGY ENDOSCOPY (Cont'd)

OVARIAN AND OTHER ADNEXAL PATHOLOGY (Continued) → WHEN TO REFER?

Initial GP Work Up – Ovarian Cysts

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) Pelvic 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 – Ovarian Cysts

- If less than 5cm in size. Repeat scan after menstrual period when applicable (can exclude such as corpus lutealcysts)
- 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.

BACK

GYNAECOLOGY ENDOSCOPY (Cont'd)

DYSPAREUNIA

Initial GP Work Up

Superficial or Deep

- If superficial only consider vaginismus and referral to Sexual Medicine and Therapy clinic (previously SARC)
- Deep- TV Pelvic US, Cervical screening test, High Vaginal Swab

Management Options for GP

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

Encourage use of lubricants and oestrogen in post-menopausal patients.

WHEN TO REFER?

Routine

Asymptomatic: Refer as soon as possible

BACK

GYNAECOLOGY ENDOSCOPY (cont'd)

ACUTE PELVIC INFLAMMATORY DISEASE

WHEN TO REFER?

Initial GP Work Up

- Symptomatology - pain, discharge, pyrexia
- Intermenstrual bleeding
- ? presence of IUCD

Investigations

- FBE/CRP
- HVS/Chlamydia, gonorrhoea, mycoplasma swabs
- First pass urine –Chlamydia and gonorrhoea PCR
- Urine culture
- Endocx/urethra l/rectal swab (if indicated)
- HCG
- CST if due

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)

Emergency

- Positive pregnancy test with pelvic pain +/- fever (consider abortion). Refer for admission
- Acutely unwell, pelvic mass, unresponsive to treatment (12-16 hours)

BACK

CHRONIC PELVIC INFLAMMATORY DISEASE

WHEN TO REFER?

Initial GP Work Up

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

Investigations

- See acute
- Ultrasound scan – including serial USS 6-12 weeks apart

Management Options for GP

Symptomatic after treatment - refer

Routine

Chronic PIO: Unresponsive to treatment

BACK

GYNAECOLOGY ENDOSCOPY (Cont'd)

PERSISTENT PELVIC PAIN

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

• Persistent pelvic pain that has not responded to adequate medical management.

Information to be included in the referral
Information that **must** be provided
• Past medical history including:
◦ obstetric and gynaecological history
◦ pain severity, duration, any link to menstrual cycle or dysmenorrhea
◦ how pain is different to any co-existing gastrointestinal pain
◦ any previous pelvic inflammatory disease
◦ any history of sexual abuse
◦ previous medical and surgical management
• Current and complete medication history (including non-prescription medicines, herbs and supplements)
• Any medicines previously tried, duration of trial and effect.

Provide if available
• Transvaginal Pelvic USS
• Up to date CST

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Specialist multidisciplinary programs for women experiencing complications with transvaginal mesh are available at:
• Royal Women's Hospital
• Mercy Hospital for Women
• Monash Health
• Western Health.

Women may also be referred to a chronic pain service.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.
-Needs review by gynaecologist prior unless referred by private gynaecologist

Referral to a public hospital is not appropriate for

Not applicable.

Continued over page

WHEN TO REFER?

Emergency

Direct to an emergency department that can provide a gynaecology assessment:

- Acute, severe pelvic or abdominal pain

Routine

If diagnosis is uncertain

BACK

GYNAECOLOGY ENDOSCOPY (Cont'd)

PERSISTENT PELVIC PAIN (Continued)

WHEN TO REFER?

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Persistent pelvic pain

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

Initial GP Work Up

Try to determine if gynaecological or gastrointestinal in origin. Take a historyof bowel habit to rule out constipation as a cause. Try to illicit if irritable bowel syndrome is the cause or contributor.

Investigations

Pelvic Ultrasound
Recent cervical screening test
High Vaginal Swab
Urine MCS

Management Options for GP

Persistent pelvic pain may be reduced by prevention of menstruation and/or ovulation. Hormonal methods may assist. Management of coexistant pathology, including IBS, anxiety, depression or pelvic floor dysfunction can reduce pain levels. Opiates, while sometimes required, should be avoided in chronic pain.

BACK

GYNAECOLOGY ONCOLOGY

CANCER OF THE CERVIX

WHEN TO REFER?

Urgent
Contact the Gynae-Oncology Unit

Initial GP Work Up

- FBE, UEC if bleeding
- CST

Management Options for GP

Refer to gynaecology

BACK

OVARIAN CANCER

WHEN TO REFER?

Urgent
Contact the Gynae-Oncology Unit

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

Management Options for GP

Refer to gynaecology

BACK

GYNAE CANCERS -SUSPECTED AND CONFIRMED

WHEN TO REFER?

Urgent
Contact the Gynae-Oncology Unit

Initial GP Work Up

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

Management Options for GP

Refer to gynaecology

BACK

MENOPAUSE

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

Management Options for GP

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

WHEN TO REFER?

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

BACK

MENOPAUSE AFTER CANCER, MENOPAUSE AFTER RISK REDUCTION SURGERY

Initial GP Work Up

Information of diagnosis, management and therapy of cancer

Management Options for GP

Refer to Menopause after cancer clinic

WHEN TO REFER?

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

BACK

PREMATURE MENOPAUSE, SURGICAL MENOPAUSE

Initial GP Work Up

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

Investigations

Hormone studies

Pelvic Ultrasound

Management Options for GP

Refer Early Menopause Clinic

WHEN TO REFER?

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

BACK

WHEN TO REFER?

Routine
Refer to Menopause Clinic

BACK

MENSTRUAL MANAGEMENT

PERSISTENT, HEAVY MENSTRUAL BLEEDING

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Persistent, heavy menstrual bleeding that has not responded to adequate trial of medical treatment.

Information to be included in the referral

Information that **must** be provided

- Findings from physical examination
- Past medical history (e.g. diabetes, polycystic ovary syndrome)
- Transvaginal pelvic ultrasound results. (Transabdominal pelvic ultrasound results can be provided for women who have not become sexually active, are a survivor of sexual assault or have declined a transvaginal pelvic ultrasound.)
- Full blood count
- Iron studies.

Provide if available

- Thyroid stimulating hormone (TSH)
- Most recent cervical screening results.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Referrals should be made to suitable community-based services wherever possible (see 1800 My Options).

Where a public health service also operates a community health service or GP clinic, demand for reproductive health services should be met through these GP clinics.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Referral to a public hospital is not appropriate for

Not applicable

Continued over page

WHEN TO REFER?

Emergency

Direct to an emergency department that can provide a gynaecology assessment:

- Uncontrolled vaginal bleeding, or if the woman is haemodynamically unstable

Urgent

Anaemia Hb < 90 g/l

BACK

MENSTRUAL MANAGEMENT (Cont'd)

PERSISTENT, HEAVY MENSTRUAL BLEEDING (Continued) > WHEN TO REFER?

SEMPHN Pathways
Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Heavy menstrual bleeding

HealthPathways
Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

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

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 --→Only requested with Cervical
- CST and endo polyps
- 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/land 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)

BARTHOLIN'S CYSTS / VAGINAL LESIONS

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

WHEN TO REFER?

Routine

For cyst management

Urgent

Infected abscess or > 60 years old

BACK

MENSTRUAL MANAGEMENT (Cont'd)

POST-MENOPAUSAL BLEEDING

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

• Post-menopausal bleeding with a thickened endometrium (>4mm measured on transvaginal pelvic ultrasound)
• Post-menopausal bleeding with polyp confirmed by imaging
• Post-menopausal bleeding in a woman taking tamoxifen.
•Persistent or unexplained bleeding

Information to be included in the referral

Information that **must** be provided
• Findings from physical examination
• Most recent cervical screening results
• Transvaginal pelvic ultrasound results.
(Transabdominal pelvic ultrasound results can be provided for women who have not become sexually active, are a survivor of sexual assault or have declined a transvaginal pelvic ultrasound.)
• Past medical history (e.g. diabetes, polycystic ovary syndrome)
• Sexually transmitted infections test results.
• High Vaginal Swab
• FBE/ Fe studies

Provide if available
• Weight
• Body mass index.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Referral to a public hospital is not appropriate for

Single episode of bleeding with an endometrium (<4mm measured on transvaginal pelvic ultrasound), with negative cervical screening results.

Continued over page

WHEN TO REFER?

Emergency

Direct to an emergency department that can provide a gynaecology assessment:

- Uncontrolled vaginal bleeding, or if the woman is haemodynamically unstable

Urgent

If endometrial thickness >10mm on ultrasound
If Hb < 90g/l

BACK

MENSTRUAL MANAGEMENT (Cont'd)

POST-MENOPAUSAL BLEEDING (Continued) WHEN TO REFER?

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Postmenopausal bleeding

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

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
- Transvaginal Pelvic ultrasound
- Pregnancy test (unnecessary >55 years)
- FBE/ Fe studies
- STI screening

Management Options for GP

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

BACK

MENSTRUAL MANAGEMENT (Cont'd)

PERSISTENT OR UNEXPLAINED INTERMENSTRUAL BLEEDING

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

• Persistent or unexplained intermenstrual bleeding.

Information to be included in the referral

Information that **must** be provided

• Most recent cervical screening results
• Transvaginal pelvic ultrasound results.
(Transabdominal pelvic ultrasound results can be provided for women who have not become sexually active, are a survivor of sexual assault or have declined a transvaginal pelvic ultrasound.)
• FBE/ Fe studies

Provide if available

• Findings from physical examination
• Past medical history (e.g. diabetes, polycystic ovary syndrome)
• Sexually transmitted infections test results.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Referral to a public hospital is not appropriate for

Not applicable.

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Intermenstrual bleeding

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

WHEN TO REFER?

Emergency

Direct to an emergency department that can provide a gynaecology assessment:

- Uncontrolled vaginal bleeding, or if the woman is haemodynamically unstable

BACK

MENSTRUAL MANAGEMENT (Cont'd)

FIBROIDS

Initial GP Work Up

- Pelvic Ultrasound
- FBE/ Fe studies
- Size and symptomology.

Management Options for GP

- Nil

WHEN TO REFER?

Routine

Asymptomatic: Refer as soon as possible

BACK

PELVIC FLOOR / UROGYNAECOLOGY

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
- Relevant infection history

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)

Consider refer to private women's health physio

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

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
- Consider refer to private women's health physio

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

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

REPRODUCTIVE MEDICINE

INFERTILITY

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 l facilitate the referral process
- Pelvic examinations – GPs, specialists

WHEN TO REFER?

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

Management Options for GP

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

BACK

PRIMARY AMENORRHOEA

Initial GP Work Up

- Age > 15
- Weight history
- Dietary and 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

WHEN TO REFER

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

Management Options for GP

Counselling and support

BACK

SECONDARY AMENORRHOEA (> 6 MONTHS)

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/Pro lactin x3*
- Testosterone / SHBG / DHEA (if hirsute)

WHEN TO REFER?

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

Management Options for GP

Counselling and support

BACK

REPRODUCTIVE MEDICINE (Cont'd)

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?

Routine
After 6 months of infertility

BACK

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

TUBALREVERSAL

Initial GP Work Up

- Basic fertility check of other partner
- For tubal reversal
  - Semen analysis

Management Options for GP

N/A

WHEN TO REFER

Routine
Refer as appropriate

BACK

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

Routine

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

SEXUAL MEDICINE AND THERAPY CLINIC

SEXUAL & RELATIONSHIP COUNSELLING

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 tovulval 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

PAEDIATRIC & ADOLESCENT GYNAECOLOGY CLINIC

PAEDIATRIC AND ADOLESCENT GYNAECOLOGY

WHEN TO REFER?

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

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

ENDOMETRIOSIS

ENDOMETRIOSIS

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Suspected endometriosis that has not responded to adequate medical management
- Significant deep dyspareunia
- Dyschezia
- Known endometriosis with associated reproductive issues
- Suspected endometrioma.

Information to be included in the referral

Information that **must** be provided

- Details of previous surgical and medical management including the course of treatment, and outcome of treatment, over the past 12 months
- Transvaginal pelvic ultrasound results. (Transabdominal pelvic ultrasound results can be provided for women who have not become sexually active, are a survivor of sexual assault or have declined a transvaginal pelvic ultrasound.)
- Functional impact of symptoms on daily activities including impact on work, study, school or carer role
- Planning for pregnancy.

Provide if available

- Description of symptoms
  - dysmenorrhoea
  - deep dyspareunia
  - dyschezia
  - history of sub-fertility
- Sexually transmitted infections test results.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Referrals may be made to suitable community-based services wherever possible (see 1800 My Options).

Where a public health service also operates a community health service or GP clinic, demand for reproductive health services should be met through these GP clinics.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

Continued over page

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Severe, uncontrolled pelvic pain
- Known endometriosis with:
  - Hydronephrosis or
  - Bowel obstruction

BACK

ENDOMETRIOSIS (Cont'd)

ENDOMETRIOSIS (Continued)

WHEN TO REFER?

Referral to a public hospital is not appropriate for
Not applicable.

SEMPHN Pathways
Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Endometriosis

HealthPathways
Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK