Gynaecology Referral Pathway for GPs to Aid Triage for Gynaecology Services in the Rotunda

For acute gynaecology (suspected torsion, acute PID, etc..) or acute early pregnancy referrals please consider discussing with Obstetrics and Gynaecology registrar on call prior to referral to ED.

All referrals for out-patient appointments can also be discussed with the Obstetrics and Gynaecology registrar as necessary.

Options for outpatients

1. General Gynaecology
2. Ambulatory Hysteroscopy
3. Adolescent Gynaecology
4. Fertility
5. Promotion of Continence
6. Perineal Clinic
7. Recurrent pregnancy loss
8. Gynaecology Ultrasound
9. Community Gynaecology/GP led clinic

For abnormal smears please follow National Referral Guidelines for Colposcopy

For early pregnancy complications please follow the EPU guidelines

For suspected ovarian cancer see HSE Ovarian Cancer referral guidelines

Problem	**Helpful examination findings and results of investigations which aid with triage***	**Urgent referral**	**Routine Referral**	**If routine consider following these appropriate steps prior to referral**
Palpable abdomino-pelvic mass not obviously fibroids/urological or gastrointestinal	Bimanual and speculum examination findings Ca 125 Pelvic Ultrasound	Presence of ascites Raised Ca125 Pelvic ultrasound suspicious for ovarian ca **See Ovarian Cancer referral guideline**	Not appropriate	**See Ovarian Cancer referral guideline**

Problem	**Helpful examination findings and results of investigations which aid with triage***	**Urgent referral**	**Routine Referral**	**If routine consider following these appropriate steps prior to referral**
Persistent symptoms suggestive of ovarian cancer in women >50 • persistent abdominal distension (women often refer to this as 'bloating') • feeling full (early satiety) and/or loss of appetite • pelvic or abdominal pain • increased urinary urgency and/or frequency	Bimanual and speculum examination findings Consider • Ca125 • Pelvic Ultrasound	**If either suspicious for ovarian cancer** **See ovarian cancer referral guideline**	As necessary	If Ca 125 and pelvic ultrasound normal no indication for referral if post menopausal If still menstruating consider routine referral
Post menopausal bleeding	Bimanual and speculum examination findings	One episode if no HRT On HRT- unexpected or prolonged bleeding **Consider direct referral to ambulatory hysteroscopy**	Not appropriate	
Suspected cervical cancer	Bimanual and speculum examination findings Suspicious cervix on speculum examination Smear	Refer colposcopy	Not appropriate	

Problem	**Helpful examination findings and results of investigations which aid with triage***	**Urgent referral**	**Routine Referral**	**If routine consider following these appropriate steps prior to referral**
Post-coital bleeding **Letters received cannot be triaged without smear result unless under 25 years**	Bimanual and speculum examination findings HVS and endocervical swabs Smear Transvaginal ultrasound report if done	See colposcopy guidelines for abnormal smears Examination suspicious for cervical/vaginal cancer **refer to colposcopy**	Under 35 with normal appearing cervix on clinical exam and normal smear with negative swab results If >35 with normal smear and normal appearance of cervix with persistent symptoms consider referral to colposcopy	Smear results Swab results Consider a transvaginal ultrasound if access
Intermenstrual bleeding	Risk factors for endometrial cancer Speculum examination Bimanual examination Smear result HVS and endocervical swab results Consider pelvic ultrasound if over 35	Physical findings suggestive of malignancy-cervical or vaginal tumour Abnormal pelvic ultrasound **If over 40 consider direct referral to ambulatory hysteroscopy**	No suspicious features for malignancy/no risk factors for endometrial cancer/under 35 years and persistent symptoms	If associated with contraception try alternative Smear result Symptom chart

Problem	**Helpful examination findings and results of investigations which aid with triage***	**Urgent referral**	**Routine Referral**	**If routine consider following these appropriate steps prior to referral**
Heavy menstrual bleeding (>3months duration)	Frequency and regularity of bleeding Bimanual and speculum examination findings FBC Latest smear result Pelvic ultrasound result	Hb <8 Abnormal ultrasound **Consider direct referral to Ambulatory hysteroscopy**	If pelvic US normal and <40 years of age consider referral to GP led clinic Unsuccessful medical management **Consider direct referral to Ambulatory hysteroscopy if >40** If sent to ambulatory hysteroscopy patient should arrive with Mirena coil to be inserted if desired	FBC result Smear up to date Pelvic US if access Trial medication- mefanamic acid and transexamic acid for 2 cycles Trial OCP Offer Mirena
Dysmenorrhoea	Bimanual and speculum exam Pelvic US results	Not appropriate	Consider if failed medical intervention	Try OCP or Mirena Arrange pelvic ultrasound if access
Dyspareunia	Bimanual and speculum exam HVS and endocervical swabs	Not appropriate	As required If abnormal exam or potential need for laparoscopy	Consider pelvic ultrasound if access

Problem	**Helpful examination findings and results of investigations which aid with triage***	**Urgent referral**	**Routine Referral**	**If routine consider following these appropriate steps prior to referral**
Ovarian Cysts (Pelvic Ultrasound performed and result available)	Bimanual and speculum examination findings Incidental finding or not Symptoms **Assess Risk of Malignancy (RMI)** Pelvic ultrasound result Tumor markers if not simple cyst and pre-menopausal Ca125 Ca19.9 hCG AFP LDH If post-menopausal (any cyst) Ca125 Ca19.9 CEA	If known cyst and symptoms of torsion refer direct to ED Suspicious features on ultrasound; sepatations, solid components, papillary projections, ascites **High RMI refer directly to Gynae-oncology in Cancer centre (>200)** Low RMI (<200) but symptomatic	Persistent simple cyst x2 ultrasounds at least 6 weeks apart in pre-menopausal woman Low RMI (<200), asymptomatic, <5cm, simple appearance, unilocular, unilateral.	If simple cyst <4cm size repeat scan after 6 weeks to exclude corpus luteal cysts in pre-menopausal woman. If repeat ultrasound normal no need for referral.
Fibroids	Assess menstrual loss and pressure/pain symptoms Bimanual and speculum exam Pelvic ultrasound results FBC	Not appropriate	If abnormal menses and anaemia or obstructive symptoms	If asymptomatic with normal menstrual pattern, normal Hb no need for referral. Organise annual pelvic ultrasound for surveillance

Problem	**Helpful examination findings and results of investigations which aid with triage***	**Urgent referral**	**Routine Referral**	**If routine consider following these appropriate steps prior to referral**
Incontinence/Voiding difficulty Promotion of continence clinic	Bimanual and speculum examination findings FBE Biochemistry Medication list MSU Recent diabetes screening results Flow/volume chart for 3 days prior to appointment	Not appropriate unless acute urinary retention due to suspected gynaecological condition	Failed response to PFE/physio No response to 2 anticholinergics if OAB	Advise pelvic floor exercises Consider physio referral Risk factors for diabetes- consider screening If OAB- trial oxybutinin,kentara or urispas, bladder drill Check bladder diary-intake Advise against caffeinated beverages especially after 6pm Treat underlying chronic cough or constipation
Pelvic organ prolapse	Symptoms ?Bladder ?Bowel Extent of prolapse/pelvic exam Details of previous pelvic surgery MSU Biochemistry	Not appropriate *If patient has an ulcerated procidentia or complete vaginal vault prolapse with failed pessary consider referral to ED after discussion with on call Registrar	Failed pessary Patient unwilling to try pessary	If asymptomatic no need for referral Consider vaginal pessary Consider local oestrogen therapy for post-menopausal women Treat underlying chronic cough or constipation

Problem	**Helpful examination findings and results of investigations which aid with triage***	**Urgent referral**	**Routine Referral**	**If routine consider following these appropriate steps prior to referral**
Oligomenorrhoea/Secondary amenorrhoea	FSH/LH Prolactin TSH Oestradiol Testosterone SHBG Pelvic ultrasound report	Not appropriate	As required	Check for pregnancy Do bloods, Pelvic ultrasound if access Check BMI Dietary/lifestyle advice
PCOS	FSH/LH Prolactin TSH Oestradiol Testosterone SHBG Pelvic US report	Not appropriate	Clarify why referring- abnormal bleeding or referral to fertility clinic if trying to conceive	Diet and lifestyle advice Dietician referral Consider pelvic ultrasound if access Consider metformin and/or OCP
Chronic pelvic pain	Associated symptoms Pelvic exam HVS Endocervical swabs Pelvic US results	Not appropriate	Abnormal findings Not responsive to medication Trying to conceive	Smear UTD Menstrual suppression- OCP, depot provera, implanon, Mirena Consider pelvic ultrasound if access

Problem	**Helpful examination findings and results of investigations which aid with triage***	**Urgent referral**	**Routine Referral**	**If routine consider following these appropriate steps prior to referral**
Primary amenorrhoea	**Refer Adolescent Gynae if <18** Secondary sexual characteristics FSH/LH TSH Prolactin		Refer Adolescent Gynae if <18	Check pregnancy Consider pelvic ultrasound if access
Permanent Contraception	For consideration of surgical sterilisation -Alternatives tried -Suitability for surgery	Not appropriate	Consider referral to GP led clinic for Mirena insertion	Try Mirena/depot/implanon Discuss vasectomy
Vulval pathology	Symptoms Examination Smear history Drug/medication history Exclude STD Exclude UTI	Ulcerated lesion in postmenopausal woman Suspected cancer Bartholin's cyst in post menopausal woman *Acute, painful enlargement of Bartholin's gland may require referral to ED	No features of malignancy/pre-menopausal woman Failed medical therapy Bartholin's gland cyst	Emollients Mild steroid cream-short course Smear UTD

Problem	**Helpful examination findings and results of investigations which aid with triage***	**Urgent referral**	**Routine Referral**	**If routine consider following these appropriate steps prior to referral**
Vaginal Discharge	Physical examination Smear UTD HVS and endocervical swabs	Suspected cancer (postmenopausal women with no signs of atrophy and other causes excluded)	Chronic discharge	Treat underlying infection Reassurance if investigations negative
Menopause (Complex medical complications, premature menopause, surgical menopause)	Menopause symptoms Medical complications (CVD, Breast cancer, significant family history of breast ca, stroke, VTE)	Not appropriate	Consider referral to GP led clinic for general menopause consultation if not premature menopause or complicated medical history If <40 with elevated FSH Surgical menopause	If over 45 with menopause symptoms for management in primary care unless medical complications If 40-45 consider referral if not responsive to treatment
Infertility Clinic	Bimanual and speculum examination findings HVS Endocervical swabs Day 2-3 FSH/LH D21 progesterone (if 28 day cycle) Prolactin AMH level Rubella status Semen analysis	Over 38 and trying to conceive >6months	Under 38 Trying to conceive >12months	Lifestyle and dietary advice Weight loss Smoking cessation Pattern of sexual intercourse

Problem	**Helpful examination findings and results of investigations which aid with triage***	**Urgent referral**	**Routine Referral**	**If routine consider following these appropriate steps prior to referral**
Perineal Clinic	Nil	In general determined prior to discharge (3^{rd} and 4^{th} degree tears) Infected perineum may need referral to the ED	Persistent, perineal pain after episiotomy or 2^{nd} degree tear Previous FGM for evaluation	Outrule infection Trial of topical instilagel treatment
Adolescent Gynaecology Clinic (<18) **NO infertility**	Pelvic exam not necessary See individual presenting complaints	See individual presenting complaints	As necessary	Diet and lifestyle For heavy or painful periods consider trial OCP
Recurrent pregnancy loss Clinic	>3 miscarriages > 2 late miscarriages No investigations necessary	>2 miscarriages over 38 years of age	All other referrals	Not necessary
Ambulatory Hysteroscopy Clinic **Please ensure patient has the IUCD with them for insertion on attendance**	Bimanual and speculum examination findings See individual presenting complaints Smear result	Post menopausal bleeding Abnormal uterine bleeding with anaemia (Hb <8) Abnormal endometrium on ultrasound	Heavy menstrual bleeding Failed medical management For IMB and PCB see individual complaints	Regular, heavy menstrual bleeding, no IMB or PCB in women under 45 years of age with normal pelvic exam consider referral to GP led clinic for Mirena

Problem	**Helpful examination findings and results of investigations which aid with triage***	**Urgent referral**	**Routine Referral**	**If routine consider following these appropriate steps prior to referral**
Community Gynaecology/GP led clinic	Regular, heavy menstrual bleeding, no IMB or PCB in women under 45 years of age Failed/Difficult IUCD insertion Missing IUCD threads Menopause consultation in women >45 with no complicated medical history	Not appropriate	All should be routine	**Please ensure patient has the IUCD with them for insertion on attendance**

*** Helpful information from examination**

If never sexually active consider early ultrasound. Pelvic exam can be deferred to Gynae OPD