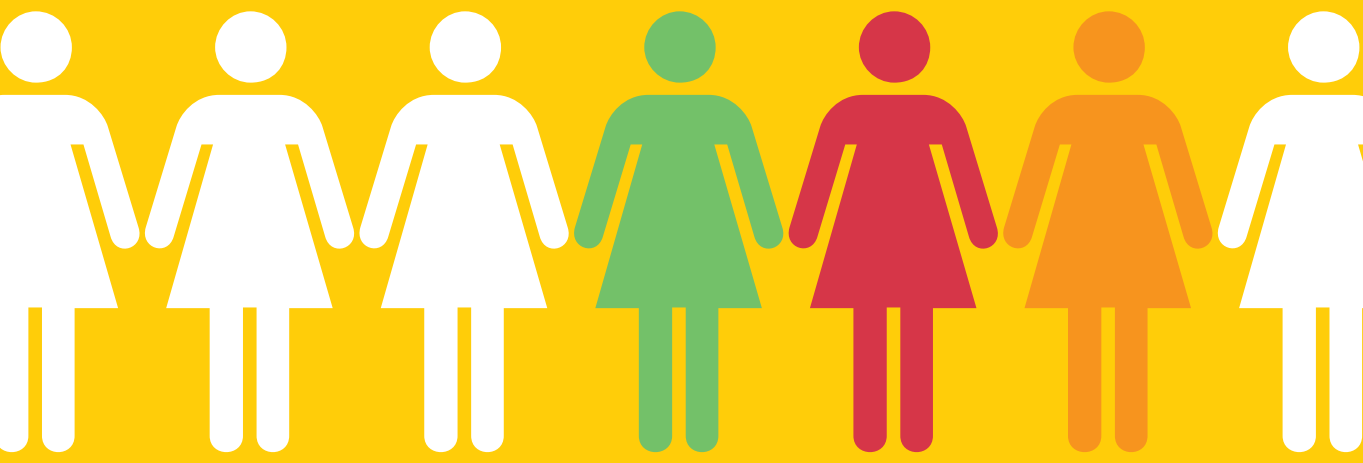
Royal College of Nursing

Women's Health Pocket Guides

2 of 3

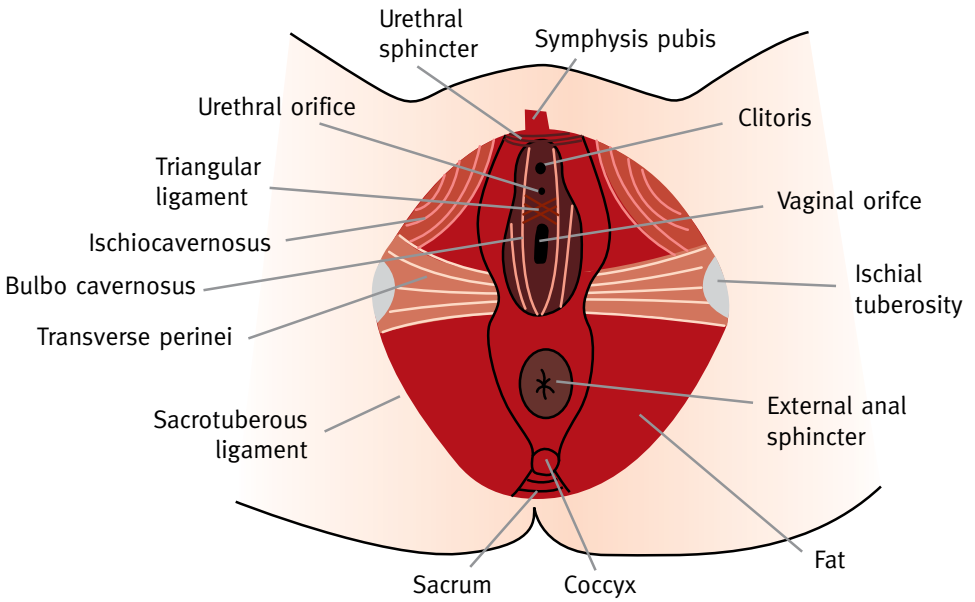


The RCN Women's Health Forum

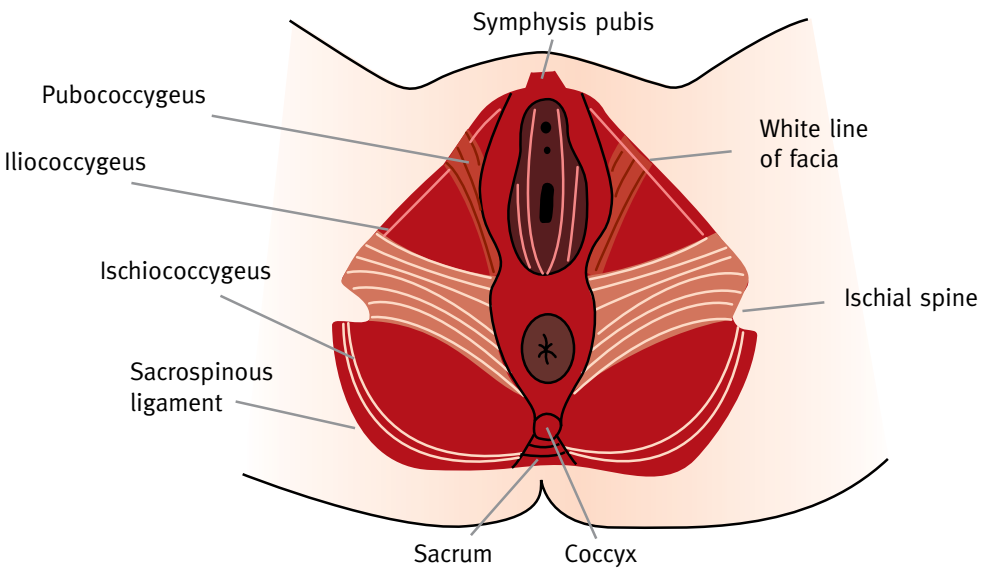
The Pelvic Floor

The bony pelvis is filled with soft tissues (muscles and ligaments) which support the abdominal and pelvic organs.

1) Superficial muscles of the pelvic floor



2) Deep muscles of the pelvic floor

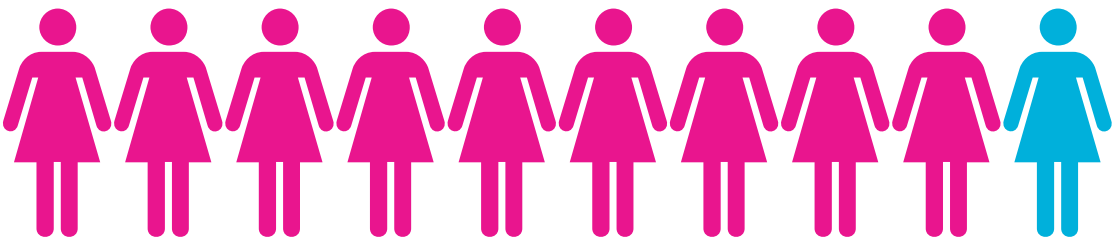


Urinary Incontinence

Type	Definition	Cause	Symptoms	Treatments
Stress incontinence	Leakage of urine on coughing, sneezing, laughing – anything that might cause a rise in intra-abdominal pressure	Childbirth, menopause, chronic cough, constipation and straining, high impact sports	Leakage with cough, sneeze, run, jump, exercise, raise in intra-abdominal pressure	Supervised pelvic floor exercises (pfe) for 3 months, vaginal cones, squeezy app, electrical stimulation for very weak pelvic floor muscles, constipation management, correct toilet position
Overactive bladder (OAB)	Urgency, with or without urge incontinence, usually with frequency and nocturia	Not known. May be worse around period, in cold weather or when patient stressed	Urgency, frequency, nocturia, urge incontinence	Pelvic floor exercises, bladder retraining, fluid advice – caffeine reduction, weight loss, exclude UTI, vaginal oestrogens, antimuscarinics, weight loss
Mixed incontinence	When symptoms of both stress incontinence and overactive bladder are present	As above	Both symptoms above	Treat most bothersome problem first – see above

Urinary Incontinence

Type	Definition	Cause	Symptoms	Treatments
Functional Incontinence	A person is usually aware of the need to urinate, but physical or mental reasons prevent them reaching a bathroom	Old age, dementia, Parkinson's, stroke, obesity, clothes, immobility	Feel urge to go to the toilet but unable to make it due to functional reasons	Occupational referral for continence aids, commode, handrail, stick and frame. Treat cause of immobility. Velcro instead of buttons and zips or elasticated underwear/ trousers. Timed and prompted voiding
Voiding difficulties	Inability to empty bladder fully/properly	UTIs, constipation, fibroid uterus, pregnancy, atonic bladder, cystocele, uterine prolapse, procidentia, abdominal tumour, previous episodes of retention	Feeling of incomplete voiding, UTIs, raised post void residuals, frequency, retention	UTI management, check post void residual, double voiding, treat constipation, teach intermittent self-catheterisation



Assessment questions

Presenting symptoms: main symptoms/duration?
Most bothersome problem?

Parity: how many children, delivery mode (caesarean, forceps, ventouse, slow/ long second stage), any tears, episiotomy or problems with perineum?

Previous gynaecology, urogynaecology, bladder or abdominal surgery

Current medications? Which affect their continence status?

Effects on quality of life (family, sex, work, socialising)

Bowel habit: frequency, constipation, IBS, diarrhoea, laxative use, do they vaginally digitate?

Oral intake: type, volume, when they drink it (bladder diary)

Tests

Urinalysis – to check for infection.

Vaginal examination – check skin integrity, pelvic floor strength, any prolapses or stress incontinence.

Post void residual.

Bladder diary – to see what they are drinking and passing and when.

Treatments

Pelvic floor exercises
2-3 sessions daily of both fast and slow twitch exercises. The 'knack' – squeeze pelvic floor prior to any raise in intra-abdominal pressure, cough, laugh, sneeze – regularity is the key.

Assessment questions

Treatments cont.

Bladder retraining

Try to train bladder back into good habits, hold on when feel urge to go, squeeze pelvic floor when experiencing urgency, increase times between voids, drop 'just in case' trips to toilet, distraction techniques, cognitive behavioural therapy.

Fluid advice

1.5-2 litres of fluid a day, reduce caffeine (tea, coffee, hot chocolate, green tea) avoid fizzy drinks and citrus drinks.

Constipation advice

Correct toilet position, good oral intake, don't put off urge, gastrocolic reflex, diet (flaxseeds, prunes etc), laxatives if needed.

UTI Prevention

Correct hygiene, good oral intake (1.5-2 litres), double voiding, cranberry capsules, d-mannose.

Medications

Antimuscarinics: to reduce urgency, frequency and urge incontinence. Non-specific so affect receptors throughout the body. Common side effects are constipation and dry mouth.

Topical vaginal oestrogens: to reduce urine infections and improve OAB symptoms. Use caution when previous breast cancer. Every night for two weeks and then twice-weekly. Continuous prescription.

Weight loss

10kg weight loss can reduce incontinence episodes by half.

Further information

NICE *Urinary Incontinence in Women: Management Clinical Guidance* (CG171) www.nice.org.uk/guidance/cg171

The Bladder and Bowel Community www.bladderandbowel.org

Contraception overview

Contraception is a collective term for methods used to prevent pregnancy and to manage some gynaecological disorders. The following provides an overview of key information.

Combined hormonal contraception

Contains oestrogen and progestogen in different delivery modes • pills • transdermal patch • vaginal ring	
Effectiveness	Around 91-99%
Benefits	• Regular bleeding pattern which may be lighter and less painful • Reduction in the risk of colorectal, ovarian and endometrial cancer • May reduce risk of fibroids / ovarian cysts / benign breast disease / endometriosis
Limitations	• User-dependent methods • Some hormonal side-effects • Vomiting or severe diarrhoea affects efficacy of pills • Drug interactions with liver enzyme-inducers and St John's Wort • Not suitable for all women – need to refer to the UK Medical Eligibility Criteria (UKMEC) for contraindications

The chosen contraceptive method should be used in combination with condoms to protect against sexually transmitted infections. Further guidance available at:

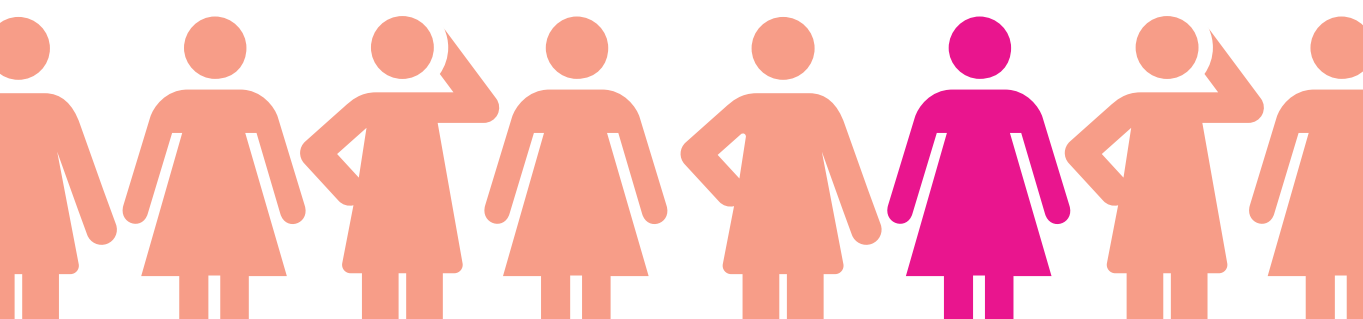
- Faculty of Sexual and Reproductive Healthcare: www.fsrh.org/home
- UK Medical Eligibility Criteria (UKMEC): www.fsrh.org/standards-and-guidance/documents/ukmec-2016
- FPA: www.fpa.org.uk
- Brook: www.brook.org.uk

Contraception

<table>
<tr><th colspan="4">Progestogen-only contraception
Progestogen in different delivery modes</th></tr>
<tr><td></td><td>Pill – daily</td><td>Implant – licensed for 3 years</td><td>Injection – every 13 weeks</td></tr>
<tr><td>Effectiveness</td><td>Around 91-99%</td><td>Around 99%</td><td>FRSH 94-99% effective and FPA 99%</td></tr>
<tr><td rowspan="2">Benefits</td><td colspan="3">No oestrogen, so suitable for most women</td></tr>
<tr><td></td><td colspan="2">Long-acting reversible contraception methods
Non-user-dependent</td></tr>
<tr><td rowspan="3">Effectiveness</td><td colspan="3">Can alter a woman's bleeding pattern
Some hormonal side-effects</td></tr>
<tr><td colspan="2">Drug interactions with liver Enzyme-inducers and St John's Wort</td><td rowspan="2">Injection cannot be removed once given.

Associated with:
• up to one years delay in, but no loss of, fertility
• weight gain, particularly in women under 18 years of age with a BMI>30
• small loss of bone mineral density, which is usually recovered after discontinuation</td></tr>
<tr><td>User-dependent method

Vomiting or severe diarrhoea affects efficacy</td><td>Needs to be fitted by a qualified person</td></tr>
</table>



Intrauterine contraception Uterine fitting by a qualified person – consider pre-insertion screening		
	Intrauterine device (IUD) Plastic and copper device licensed for 5-10 years	Intrauterine system (IUS) Progestogen-releasing plastic device licensed for 3-5 years
Effectiveness	Over 99%	
Benefits	Long-Acting Reversible Contraception methods Can be fitted at the time of surgical abortion	
	• Non-hormonal • Can be used for emergency contraception	• Lighter bleeding • 1st line choice for heavy menstrual bleeding* • Licensed alternative route for HRT progestogen*
Limitations	Periods may be longer, heavier, or more painful	Irregular bleeding or spotting in the first 6 months
	Risk of: • Expulsion: around 1 in 20 – most common in first year of use, especially first 3 months • Perforation of uterus, bowel, bladder: up to 2 per 1,000 insertions • Pelvic infection – slightly increased at insertion, and for the first 20 days afterwards	
*Mirena for HRT and hyperplasia		

Printing costs supported by a grant from Bayer plc. The company has had no input into the editorial content of these cards.
www.contraception.co.uk

Contraception

<table>
<tr><th colspan="7">Other methods</th></tr>
<tr><td></td><td>Female condom</td><td>Male condom</td><td>Diaphragm/ cap</td><td>Male sterilisation</td><td>Female sterilisation</td><td>Natural methods</td></tr>
<tr><td>Effectiveness</td><td>Female 95% (FRSH)</td><td>Male 98% (FRSH)</td><td>92-96% (FRSH and FPA)</td><td>Failure rate: approx. 1 in 2,000</td><td>Failure rate: approx. 1 in 200</td><td>Approx. 76%</td></tr>
<tr><td>Benefits</td><td colspan="2">Protection against sexually transmitted infections</td><td>Can insert ahead of intercourse</td><td colspan="2">Non-user-dependent methods</td><td>No physical side-effects</td></tr>
<tr><td rowspan="2">Limitations</td><td colspan="2">User dependent methods
Must be used correctly and consistently</td><td rowspan="2">Must be left in-situ for a minimum of 6 hours after sex</td><td colspan="2">Permanent method

Contraception needed until sterilisation is effective

Risk of post-op complications</td><td rowspan="2">Need to avoid sex at fertile time</td></tr>
<tr><td colspan="2"></td><td>Small risk of post-op testicle pain</td><td>Small risk of ectopic pregnancy if sterilisation fails</td></tr>
<tr><td colspan="7">Emergency contraception
Reduces risk of pregnancy following unprotected sexual intercourse (UPSI)
www.fsrh.org/standards-and-guidance/current-clinical-guidance</td></tr>
<tr><td></td><td>Levonorgestrel pill</td><td>Ulipristral acetate pill</td><td>Emergency IUD</td></tr>
<tr><td>Licensed use after UPSI</td><td>72 hours</td><td>120 hours</td><td>120 hours after UPSI or up to Day 19 of a 28 day cycle</td></tr>
</table>

Sexual Health and Sexually Transmitted Infections (STIs)

Sexual health is "a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence". It is concerned with sexual wellbeing, infections and disease, as well as contraception.

WHO *Defining Sexual Health* (2017) www.who.int/topics/sexual_health/en/

Sexually transmitted infections are infections that can be transferred from one person to another through unprotected vaginal, anal or oral sex, by genital contact and through sharing sex toys.

Diagnosis

- History
- Examination
- Genital examination – including vaginal and cervical examination
- Self-swabs (vaginal, anal and throat)
- Urine sample
- Bloods (blood borne viruses)

	Signs and symptoms
Bacterial Chlamydia (CT)	Most women experience no symptoms. Dysuria, unusual vaginal discharge, lower abdominal pain or tenderness, dyspareunia, bleeding during or after sex or between periods. It can also cause heavy periods. CT infection may also be in the rectum, throat or eyes.
Gonorrhoea (GC)	About 50% women experience no symptoms. Unusual vaginal discharge (thin or watery, yellow or green). Dysuria, lower abdominal pain or tenderness. Rarely, bleeding between periods or heavier periods. GC infection may also be in the rectum, throat or eyes.

Sexual Health and Sexually Transmitted Infections (STIs)

	Signs and symptoms
Bacterial Syphilis	Syphilis in the early stages causes a painless, but highly infectious sore on the genitals or around the mouth. The sore can last up to six weeks before disappearing. Secondary symptoms such as a rash, flu-like illness or patchy hair loss may then develop. These may disappear within a few weeks. The late or tertiary stage of syphilis usually occurs after many years, and can cause serious conditions such as heart problems, paralysis and blindness. The symptoms of syphilis can be difficult to recognise.
Viral Genital herpes	Feeling generally unwell with flu-like symptoms such as fever, tiredness, headache, swollen glands, aches and pains in the lower back and down the legs or in the groin. This will be followed by: Small, fluid-filled blisters anywhere in the genital or anal area, on the buttocks and the tops of the thighs. These burst within a day or two leaving small, red sores which can be very painful.
Genital warts	Flat or smooth small bumps or quite large, pink, cauliflower-like lumps. Genital warts are usually painless but may occasionally itch and cause some inflammation.
HIV	Many people who are living with HIV have no obvious signs and symptoms. Recent evidence shows that between 70% to 90% of people who become infected with HIV experience flu-like symptoms within a few weeks after infection. The most common symptoms are a fever, a rash and a severe sore throat all occurring at the same time. These symptoms in an otherwise healthy person may indicate recent HIV infection.
Parasites Trichomoniasis	Unusual vaginal discharge (frothy yellow or watery) that has an unpleasant smell, soreness or itching around the vagina, dysuria.

Sexual Health and Sexually Transmitted Infections (STIs)

	Signs and symptoms
Parasites Pubic Lice	Black powdery droppings from the lice in your underwear. Brown eggs on pubic or other body hair. Irritation and inflammation in the affected area, sometimes caused by scratching.
Scabies	An itchy red rash or tiny spots.

Treatments

Treatments vary depending on the STI and history. Please refer to BASHH Guidelines for the latest treatment managements – www.bashh.org/guidelines. Ensure treatment compliance.

Partner notification

Contact tracing of sexual partners is an important part of clinical management. Clinicians diagnosing STIs are responsible for contract tracing so that partners can be treated and tested.

Prevention

- Using a condom every time for vaginal or anal sex
- Not sharing sex toys
- Using a condom on a penis when giving males oral sex
- Using dental dams to cover the female genitals during oral sex or when rubbing female genitals together

Faculty of Sexual and Reproductive Health – www.fsrh.org/home

Further reading

British Association for Sexual Health and HIV (BASHH) www.bashh.org

Search for a sexual health clinic across the UK www.bashh.org/clinics

Family Planning Association FPA – Sept 2017 – Contraceptive methods that don't depend on you remembering to take or use them. www.fpa.org.uk/help-and-advice/contraception-help

Uterine Fibroids

Fibroids

- Benign tumours of myometrium with a clinically relevant prevalence in 30% of women of reproductive age
- Single or multiple and measure 1-20mm
- Their growth is influenced by oestrogen and progesterone
- They can enlarge during pregnancy and they shrink post-menopausally

Risk factors

- Early menarche
- Nulliparity
- Increasing age (30-40s)
- Obesity
- Race (more common in women of Afro-Caribbean origin).
- Steroid hormone concentrations.
- Angiogenic growth factor abnormalities

Types (see figure 1)

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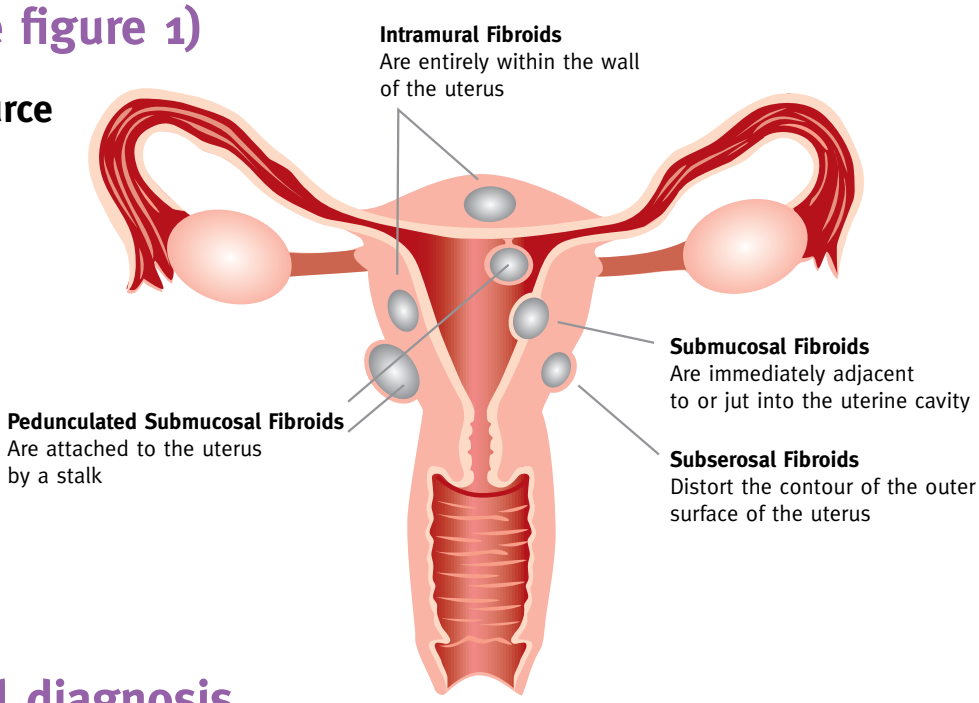
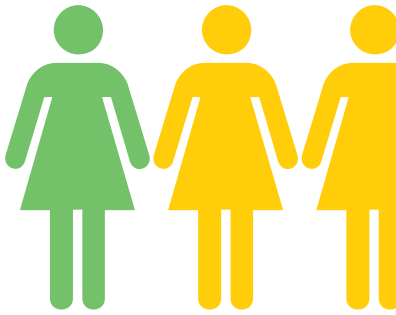


Differential diagnosis

- Malignancy (e.g. ovarian cancer, endometrial cancer, leiomyosarcoma)
- Other benign causes (e.g. ovarian cyst, adenomyosis)
- Other causes (e.g. pregnancy)

Uterine Fibroids



Symptoms

50% will be asymptomatic

- Heavy menstrual bleeding (HMB); possible intermenstrual/postcoital bleeding
- Anaemia (due to HMB)
- Dysmenorrhoea associated with heavy bleeding
- Pressure symptoms (bowel, bladder, dyspareunia)
- Pelvic pain and swelling (large uterus)
- Reproductive dysfunction (subfertility, pregnancy loss)

Diagnosis and investigations

- Bimanual and speculum
- Full blood count (if bleeding a symptom)
- Ultrasound scan (USS) – to confirm number, size and location of fibroids
- Magnetic resonance imaging (MRI) (unclear USS / pre-surgery).
- Hysteroscopy – evaluates extent of uterine fibroids / examines endometrium + biopsy
- Sonohysterography – evaluates submucosal fibroids.
- Laparoscopy – excludes pelvic pathology

Treatments

Treatment will be based on a number of factors including age, reproductive plans, severalty of symptoms, size and location of fibroids and preferences.

Pharmacological

Hormonal	Non-hormonal
• Levonorgestrel-releasing intrauterine system* • combined oral contraceptives** • oral progesterone or injectable progesterone**	• Tranexamic acid** • non-steroidal anti-inflammatory preparations**

Non-pharmacological

Surgery	Radiological
• endometrial ablation** • myomectomy • hysterectomy	• Uterine artery embolisation • MRI-guided focused ultrasound intervention

** Contraindicated for fibroids distorting uterine cavity*
*** Contraindicated for fibroids ›3cm diameter*

Further information

Fibroid Network: www.fibroid.network

British Fibroid Trust: www.britishfibroidtrust.org.uk/support_grp_mtg.php

Fibroid Treatment NHS Choices: www.nhs.uk/Conditions/Fibroids/Pages/Treatment.aspx

NICE clinical knowledge summary for uterine fibroids, updated February 2013 www.nice.org.uk/guidance/conditions-and-diseases/gynaecological-conditions/endometriosis-and-fibroids

NICE clinical guideline CG44. *Heavy menstrual bleeding: assessment and management* updated August 2016. www.nice.org.uk/guidance/cg44

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www.medtronic.com/covidien

Cervical polyps

Cervical polyps are generally benign overgrowths of tissue at the external os or just inside the internal cervical canal.

They are common and the exact cause is unknown.

Symptoms may include:

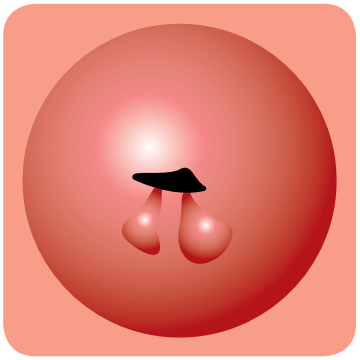
- none, as it may only be found on examinations and at cervical screening
- intermenstrual bleeding (IMB)
- post coital bleeding (PCB)
- vaginal discharge
- post-menopausal bleeding (PMB).

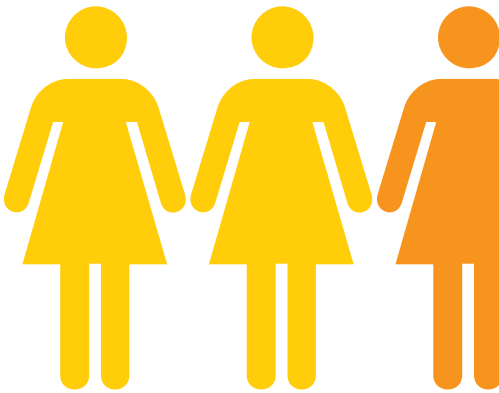
Cervical polyps should be removed (and sent for histology) by:

- avulsion (twisting the polyp) and it will then come away with its base if it is cervical
- diathermy.

Women with polyps in the post-menopause are more likely to have a concurrent endometrial polyp so should have ultrasound performed.

Cervical polyps
As viewed through a speculum





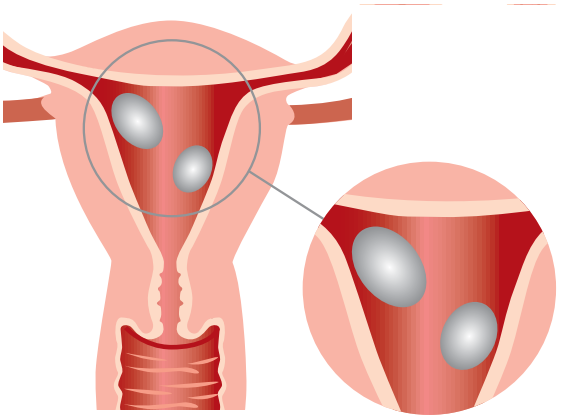
Endometrial polyps

Endometrial polyps are dense, fibrous tissue, with blood vessels and glands lined with endometrial epithelium and can reoccur after removal. They are a common finding on ultrasound, and will regress if small. They:

- can be single or multiple
- range from a few millimeters to 5-6cm.

Risk factors

- Age
- Hypertension
- Obesity
- Tamoxifen
- High oestrogen



Endometrial polyps

Treatment

- Hysteroscopic assessment if seen on ultrasound.
- None – smaller ones may regress (20%)
- Hysteroscopic resection
- Not blind curettage which can miss the polyp and lead to a higher chance of regrowth
- Histological abnormalities are normally within the base of the polyp

Symptoms

- Intermenstrual bleeding (IMB)
- Post Coital bleeding (PCB)
- Heavy periods (HMB)
- None, seen on scan
- Linked with fertility issues and miscarriage
- Post-menopausal bleeding (PMB) (estimated that there is an 8% malignancy rate)

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Cervical and Breast screening

Cervical screening (the smear test), is part of the **NHS Cervical Screening Programme** (CSP), screens women aged 25-64 for cervical abnormalities. Early detection allows monitoring and treatment to prevent progression to cervical cancer.

A sample of cells from the cervix is obtained and tested for the presence of abnormal cells and the Human Papilloma Virus (HPV). HPV is a normal consequences of sexual intercourse, and 50-79% of women who have sexual intercourse have a lifetime risk of HPV infection.

The CSP pathway, HPV triage and test of cure, is a programme using reflex testing for high-risk HPV (HR-HPV) to manage women with cytology results that show borderline changes or mild dyskaryosis. Cervical abnormalities requiring treatment are present in approximately 15-20% of the women who are HR-HPV positive.

For management of abnormal smear results please refer to NHSCSP www.gov.uk/government/publications/cervical-screening-programme-and-colposcopy-management

	NHS Cervical Screening Programme
Age	**Cervical screening interval**
25 (24 + 6 months)	First invitation to screening
25-49	3-yearly screening
50-64	5-yearly screening
65+	Cease cervical screening

Cervical and Breast screening

Breast screening is routinely carried out on women aged 50-70 every three years (unless high risk determined).

Breast screening helps to detect cancer earlier, allowing treatment to commence earlier, which gives a greater chance of successful and less destructive treatment.

Mammography is the most common screening test. Some women may have MRI (magnetic resonance imaging) if there is an elevated risk of cancer, or the breast tissue is dense.

Further reading

RCN HPV, *Cervical Screening and Cervical Cancer Practice Guidelines* (in press 2017/8)

Cervical Screening Programme. *HPV Triage and Test of Cure Implementation Guide... NHSCSP Good Practice Guide No3.* July 2011
www.csp.nhs.uk/files/F000198_F000196_NHSCSP%20Good%20Practice%20Guide%20no%203%20HPV%20implementation%20guidance.pdf

Breast screening (2017) Cancer research UK
www.cancerresearchuk.org/about-cancer/breast-cancer/screening/breast-screening

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Cervical cancer

Cancer of the cervix is almost 100% preventable with correct implementation and uptake NHS cervical screening programme (NHSCSP). It accounts for 900 deaths/year in the UK, with 1 in 135 women diagnosed.

Cervical cancer survival

The mortality rate has dropped by 72% since the early 1970s, with 63% of women surviving cervical cancer for 10 or more years, with survival rates highest in patients under 40.

Causes/risks	Signs & symptoms
Predominantly lifestyle oriented. • human papillomavirus (HPV) – biggest risk factor present in 100% of cases. • tobacco smoking and human immunodeficiency virus (HIV) type 1, can be linked to HPV infection. • Oestrogen-progestogen contraceptives and in utero exposure to diethylstilbestrol also have strong evidential links to cervical cancer.	1/4 through screening programme. 1/3 routine or urgent GP attendances 1/5 2-week wait referral route. Signs are: - abnormal vaginal bleeding - post cotial bleeding - vaginal discharge Types: - squamous - adeno carcinoma

Cervical cancer

Diagnosis	Treatment
Colposcopy (a detailed examination of the cervix using an illuminated microscope) as diagnosis, plus biopsies. In small lesions LLETZ (large loop excision of the transformation zone) can be used to remove the area in clinic under local anesthetist. More advanced may have Examination under Anaesthetic to check surrounding organs for signs of invasive disease. Further investigations: Computerised tomography (CT) scan. Magnetic resonance imaging (MRI) scan. Chest X-ray. Positive emission tomography (PET) scan.	Treatment is dependent on the stage of the cancer, and the woman's preferences. Surgery is the most common. Early stage cervical cancer may be radiotherapy, surgery or a combination of both. If the cancer is more advanced, surgery can be paired with chemotherapy and / or radiotherapy. - Cone biopsy/ Large excision - Hysterectomy - Trachelectomy - Internal radiotherapy (brachytherapy) - Radical hysterectomy - External radiotherapy chemotherapy

Resources

Macmillan's online community community.macmillan.org.uk

Cancer Research UK www.cancerresearchuk.org

RCN HPV, Cervical Screening and Cervical Cancer Practice Guidelines (in press 2017/8)

Cervical Screening Programme UK Overview (2017) www.gov.uk/guidance/cervical-screening-programme-overview

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Cancer of the Vagina

Cancer of the vagina is the abnormal growth of vaginal tissue either locally or spread to neighbouring tissue, cervix or bladder. In the UK approximately 300 women a year are diagnosed.

Causes/Risks
Age (majority over 60)
HPV (human papilloma virus)
VAIN (vaginal intra-epithelial neoplasia) or CIN (cervical intra-epithelial neoplasia) – pre-cancers
History of pelvic radiotherapy (rare)
DES (Diethylstilbestrol) (last given in the 1970s)

Signs & Symptoms
Blood-stained vaginal discharge
Bleeding after the menopause, between periods or after sex
Pain passing urine
Pain in pelvis
Constipation/tenesmus
Lump in vagina

Diagnosis
History taking
Examination
Biopsy
MRI/chest X-ray or CT chest scan and/or PET scan

Types
Squamous cell carcinoma
Adenocarcinoma

Treatment
One of more combinations of treatment:
Chemoradiation
External Beam Radiotherapy (first line)
Surgery (vaginectomy)
Adjuvant radiotherapy (after surgery)
Brachytherapy (inserting radioactive material directly into the affected area)
Chemotherapy (wide spread disease)

Further reading

Macmillan's online community community.macmillan.org.uk/
Cancer Research UK www.cancerresearchuk.org

Cancer of the Vulva

This is the abnormal growth of vulval tissue with the capacity to grow locally or spread into neighbouring tissue. Approximately 1000 women are diagnosed in the UK every year.

Causes/risks
Age (80% over 60)
HPV – types 16/18 and 31
VIN (vulval intra-epithelial neoplasia) – pre-cancer
Lichen sclerosus/lichen planus
Smoking

Signs & symptoms
Lump/mole
Ulcer
Itch, burning, soreness
White/dark patches
Thickened area
Bleeding

Diagnosis
History and examination
Biopsy
MRI/chest X-ray or CT chest scan and/or PET scan

Types
Squamous cell carcinoma (90%)

Treatments
Surgery:
Wide local excision
Partial/Radical vulvectomy
+/- Unilateral or bilateral groin node dissection
+/- sentinel node biopsies
Radiotherapy: External beam
Brachytherapy (inserting radioactive material directly into the affected area.)
Chemotherapy used with radiotherapy
chemoradiation alone for disease spread

Side-effects of treatment
Lymphoedema
Vaginal fibrosis
Body image/sexual problems

Further reading

Macmillan's online community community.macmillan.org.uk/
Cancer Research UK www.cancerresearchuk.org
The Eve Appeal Gynaecological Cancer Research Charity www.eveappeal.org.uk
Gynae C – Support Group www.canceradvice.co.uk/support-groups/gynae-c/
Vulval Awareness Campaign Organisation www.vaco.co.uk

Surgical Termination of Pregnancy

Surgical termination of pregnancy involves the physical removal of a viable pregnancy from the uterus by:

- aspiration (manual vacuum or electric vacuum) to approximately 14 weeks gestation
- evacuation with surgical instruments (dilatation and evacuation – D&E) with/without vacuum aspiration from approximately 14 weeks gestation.

Options for pain management

Vacuum aspiration: local anaesthetic, conscious sedation or general anaesthetic.

D&E: general anaesthetic or conscious sedation.

Cervical preparation

Involves the preparation of the cervix prior to surgical abortion, in order to make the cervix easier to dilate, to facilitate passage of surgical instruments or suction cannulae.

Cervical preparation can be:

- mechanical, by the insertion of osmotic dilators (small, absorbent rods) into the cervix which gently swell and dilate the cervical opening
- alternatively, or in addition, it can be chemical, with the use of misoprostol or mifepristone to soften the cervix.

Possible complications of surgical abortion

- Retained products of conception (uncommon)
- Infection (rare)
- Unpredictable bleeding after the abortion.

Surgical Termination of Pregnancy

Possible complications of surgical abortion (cont.)

- Pain during procedure.
- Continuing pregnancy (rare for vacuum aspiration; very rare for D&E).
- Psychological problems.
- Haemorrhage (rare for vacuum aspiration; uncommon for D&E).
- Injury to cervix, uterus (including perforation and possibly resulting in hysterectomy), bowel or bladder (rare to very rare).
- Death (very rare).

Follow up after surgical abortion

- Routine follow up not necessary because successful surgical abortion should be confirmed at the time of the procedure by visual means.
- Clear verbal and written information about complications (lasting pain, excessive bleeding, offensive vaginal discharge, abdominal tenderness, fever, generally feeling unwell) and when and how to seek help.
- Access to 24/7 telephone helpline for clinical advice post-treatment
- Fertility returns as early as 10 days following procedure.
- Appropriate contraception should be offered at the time of the abortion.

Further reading

RCN (2017) *Termination of Pregnancy* www.rcn.org.uk/professional-development/publications/pub-005957

RCOG (2011) *The Care of Women Requesting Induced Abortion* www.rcog.org.uk/en/guidelines-research-services/guidelines/the-care-of-women-requesting-induced-abortion/

Miscarriage

The spontaneous loss of a pregnancy before 24 weeks gestation with associated emotional distress.

1st Trimester Miscarriage (up to 12+6 weeks)

Incidence: Approximately 1 in 4 pregnancies

Classification

- Complete miscarriage – all pregnancy tissue has spontaneously miscarried & the bleeding has stopped
- Incomplete miscarriage – some pregnancy tissue is remaining in the uterus
- Missed miscarriage – the baby has died but remains in the uterus

Treatment options Clear information = informed choice

	Natural	Medical	Surgical under LA	Surgical under GA
Definition	Miscarriage happens naturally	Medication is used to induce the miscarriage, usually misoprostol	A catheter is inserted into the uterus after local anaesthesia and analgesia has been given, gentle suction is used to remove the pregnancy	A catheter is inserted into the uterus after general anaesthesia, gentle suction is used to remove the pregnancy
Advantages	- Natural process - No medication - No hospital admission - Could happen at home and with partner/other supporter	- No anaesthetic - No hospital admission if under 10 weeks gestation - Usually at home so partner/other supporter could be present	- Timing predictable - Staff support during procedure - No anaesthetic - Partner/family member can usually be present	- Timing predictable - Asleep and unaware during procedure
Disadvantages	- Timescale to miscarrying unpredictable and could happen anywhere - Pain/bleeding at home may cause anxiety - Possible acute hospital admission - May fail and require medical/ surgical treatment	- Pain/bleeding at home can cause anxiety - Possible acute hospital admission - Success of treatment 85-90% - May fail and require surgical treatment	- May be painful/ distressing during procedure - Potential complication of surgery (e.g. perforation, cervical trauma) - 5% risk of failure that may require repeat procedure	- Hospital day admission - Partner/family member not present - Potential complication of surgery (e.g. perforation, cervical trauma) - 5% risk of failure that may require repeat procedure

2nd Trimester Miscarriage (13 to 23+6 weeks)

Incidence: approximately 1 in 100 pregnancies

It is important to discuss whether the couple wish to see the baby and/or hold their baby, create memories like hand and foot prints, locks of hair, clothes if they wish the baby to be dressed, post-mortem, funeral/cremation arrangements.

The risks of bleeding, infection and retained tissue are much higher with second trimester miscarriage, so outpatient management is not usually recommended.

Treatment options Clear information = informed choice, natural choice is an option is some cases if the miscarriage is in progress.

	Medical	Surgical under GA
Definition	- Medication is used to induce the miscarriage, usually with - Mifepristone 48 hours prior to admission for misoprostol	- Up to 15 weeks a catheter is inserted into the uterus after general anaesthesia, gentle suction is used to remove the pregnancy. - Above 15 weeks different instruments are used and the procedure is more difficult, so primary surgery is not available in all hospitals.
Advantages	- No anaesthetic - Analgesia - Staff support - Be with partner/other supporter	- Timing predictable - Asleep during procedure
Disadvantages	- May require repeated doses of medication - May require surgical treatment in the event of heavy bleeding or to remove the placenta - Success of treatment 85-90%	- Hospital day admission - Partner/family member not present - Potential complications of surgery

Further reading

NICE (2014) *Ectopic pregnancy and miscarriage* www.nice.org.uk/guidance

Association of Early Pregnancy Units (AEPU) www.aepu.org.uk

Miscarriage Association www.miscarriageassociation.org.uk

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Anti-D

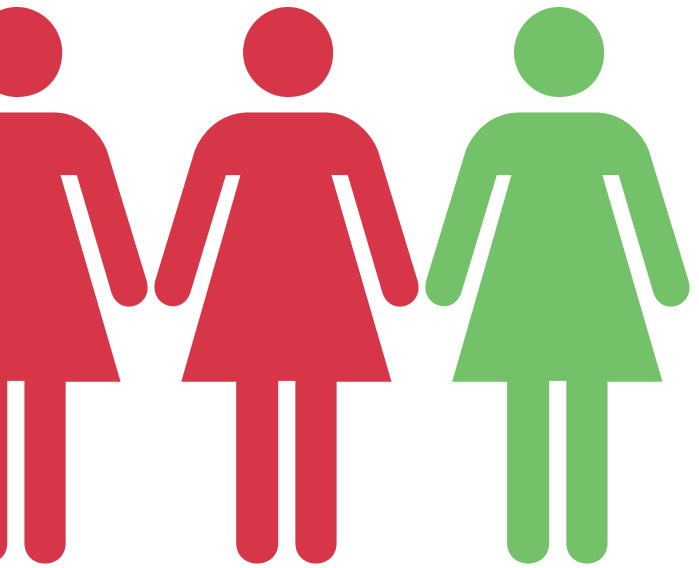
Anti-D or anti-D immunoglobulin is administered to women who may be at risk of Rhesus disease; it can help to avoid a process called sensitisation, which is when a woman with RhD negative blood is exposed to RhD positive blood and may develop an immune response to it.

Current practice is to offer anti-D rhesus prophylaxis at a dose of 250 IU (50 micrograms) to all rhesus negative women who have a surgical procedure to manage an ectopic pregnancy or a miscarriage.

Do not offer anti-D rhesus prophylaxis to women who:

- receive solely medical management for an ectopic pregnancy or miscarriage or
- have a threatened miscarriage or
- have a complete miscarriage or
- have a pregnancy of unknown location.

Do not use a Kleihauer test for quantifying feto-maternal haemorrhage.



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