Royal College of Nursing

Women's Health Pocket Guides

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The RCN Women's Health Forum

2 Fertility Preservation

Fertility preservation involves freezing and storing sperm or eggs (gametes), ovarian reproductive material or embryos for use in a person's future fertility treatment.

Techniques for storing gametes and embryos are now well established and progress has also been made with the preservation of ovarian and testicular reproductive material.

Good quality information, informed consent and appropriate counselling are critical before preservation can begin, but it must be managed early.

Legal and regulation issues

Storage and the use of gametes and embryos falls under the regulatory remit of the Human Fertilisation and Embryology Authority (HFEA), which also provides information about HFEA licensed fertility centres across the UK.

The main legislation around fertility preservation is:

- Human Fertilisation and Embryology Act 1990 (amended) (HFE Act)
- Human Tissue Act 2004, use and storage of ovarian and testicular reproductive material

Reason for preserving fertility

- Medical – life limiting disorders
- Transgender reassignment
- Social/economic – wishing to delay becoming pregnant

Resources

RCN (2017) *Fertility Preservation*
www.rcn.org.uk/professional-development/publications/pub-005986

Fertility Care

Infertility is defined by WHO (2018) as the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse.

About 80% of couples will conceive naturally, however 1:7-8 women across the globe will have difficulty and require treatment for infertility. There are also non-medical reasons for choosing fertility care, including same sex individuals/couples or transgender people who seek infertility care, or those who choose to defer their child bearing until a suitable time for them.

Causes

- 1/3 male associated physiology
- 1/3 female related physiology
- 1/3 other (e.g. single women/same sex relationships)/ unknown causes

Options

- Some people will choose not to pursue treatment
- People who ask for medical advice should have appropriate investigations and referral to a fertility specialist, and if indicated follow a care pathway based on the NICE guideline
- For some, a technical solution is the option, via reproductive technologies to achieve a pregnancy, this may be in the form of IVF (In vitro fertilisation) or similar techniques
- This may require the use of donor gametes
- Fostering or adoption may be an option and information should be provided
- Surrogacy may be an option in some cases

4 Mental Wellbeing and Fertility

Confirming infertility or accessing and using treatment options can be an emotional rollercoaster, requiring the right level of support and counselling at the right time. All health care professionals should be aware of people's emotional as well as clinical needs.

All assisted conception clinics in the UK are legally required to offer their patients information and support counselling and the counsellors are expected to be accredited by the British Infertility Counselling Association or equivalent.

Resources

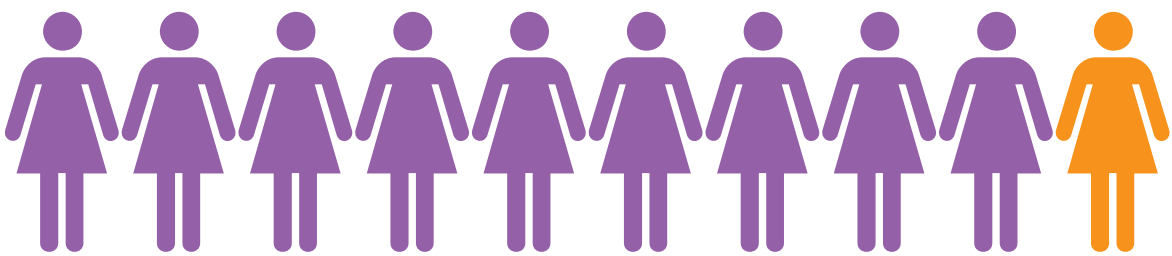
Human Fertilisation & Embryology Authority (HFEA)
www.hfea.gov.uk

Getting started (2018) HFEA guide to Treatment
www.hfea.gov.uk/about-us/publications/

British Infertility Counselling Association (BICA)
www.bica.net

Fertility Network UK
www.fertilitynetworkuk.org

NICE Guideline (2017) Fertility problems: assessment and treatment
www.nice.org.uk/guidance/cg156



Vaginal Discharge

Vaginal discharge is normal and healthy, and changes during the menstrual cycle, thinning at ovulation. Unusual changes need investigation. Full medical, sexual history and examination required (see p.11 *Women's Health Pocket Guides* 2 of 3).

Condition	Symptoms	Treatment - see BASHH Guidelines
Bacterial Vaginosis	• Watery yellow discharge • Fishy odour • ^PH	• Avoid fragranced shower gels/douching • Oral/intra vaginal antibiotics
Candida (Thrush)	• Thick white curd-like discharge • Itchy vulva • Inflammation	• Avoid fragranced soaps/gels • 80% resolve with oral/ topical azoles • Consider immunosuppression /diabetes
Cervical Ectropion	• Increased discharge • +/- spotting	• Visualise cervix • Refer to gynaecology if treatment required
Retained foreign body	• Smelly discharge • Bleeding • Discomfort	• Remove foreign body • Consider antibiotics
Sexually Transmitted Infections • Chlamydia • Gonorrhoea • Trichomonas • Pelvic Inflammatory Disease	• Increased discharge • +/- frothy discharge • Clear/yellow/green • Odour/odourless • +/-Pain passing urine • +/- abdominal pain	• Antibiotics • Abstain from sex during treatment • Treat partners • Follow-up may be required

Resources

RCN (2016) Genital examination in women www.rcn.org.uk/professional-development/publications/pub-005480

The British Association for Sexual Health and HIV - BASHH Guidelines www.bashh.org/guidelines

Jo's Cervical Cancer Trust (2018) Cervical ectropion (cervical erosion) www.jostrust.org.uk/about-cervical-cancer

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Pelvic Inflammatory Disease (PID)

PID is inflammation of the reproductive organs.

- Usually caused by a bacterial infection
- Caused by sexually transmitted infection in ¼ of women. Most commonly chlamydia, gonorrhoea, or mycoplasma genitalium
- Left untreated, can lead to pelvic scarring, pelvic abscess and infertility

Symptoms

- Lower abdominal pain
- Deep pain during sex (dyspareunia)
- +/- Abnormal vaginal bleeding
- Abnormal vaginal discharge
- Fever or feeling unwell
- May be asymptomatic

Diagnosis

- Sexual health history
- Full sexual health screen including tests for mycoplasma genitalium and blood borne viruses
- Bimanual examination
- Urine test to exclude pregnancy and urinary tract infection

Management

- 2 weeks antibiotics, analgesics and rest
- Abstain from any sexual contact for 2 weeks
- Partner notification & treatment
- Patient information, support, encourage safer sex
- Follow up in 2-4 weeks
- Admission for intravenous antibiotics if pregnant, severe symptoms or complications
- Pelvic scanning and specialist treatment required if acutely unwell or non-responding to treatment

Resources

BASHH (2012) *UK National Guideline for the Management of Pelvic Inflammatory Disease* www.bashh.org/guidelines

Polycystic Ovarian Syndrome (PCOS)

Endocrine condition with gynaecological and metabolic elements (affects ovaries, uterus, liver and adrenals) with multiple presentations affecting up to 10% of women of reproductive age.

- Harder to diagnose in young girls who have just started periods
- Unknown causes, possible genetic link, fetal exposure to androgens
- Multiple small follicles with persistently high Luteinising Hormone (LH), which inhibits ovulation, leading to high androgens

Differential diagnosis

- Thyroid dysfunction
- Pituitary tumours
- Premature ovarian insufficiency
- Hypogonadotropic hypogonadism – in women with anorexia/excessive exercise
- Drug use
- Rare endocrine e.g. adrenal hyperplasia

Signs and symptoms

- None
- Irregular/no periods (70%)
- Infertility
- Increase in hair - hirsutism (70%)
- Male pattern baldness (5-10%)
- Acne (15-25%)
- Weight gain and obesity (45%)

Diagnosis - 2 of the following

- Menstrual disturbance - infrequent or no periods
- Androgen symptoms
- PCO seen on scan

Supported by verity
sharing the truth about PCOS

Diagnosis	Results
FSH/LH	Normal FSH, raised LH ratio >2:1
Oestrogen	High
Prolactin	Normal or slightly raised
TSH	If no periods
17-hydroxyprogesterone	If no periods (adrenal hyperplasia)
Testosterone	High
Glucose /GGT/ lipids	Check diabetes and risk factors
Pelvic scan	- Multiple small follicles on the ovaries, larger ovarian volume - Endometrial thickness - Polycystic ovaries can be seen on those who do not have PCOS

Treatments (Depends on the presenting symptoms)

Lifestyle advice: weight management (ovulation after 5-6% weight loss) and benefit on CVD (cardiovascular disease) and long term health.

1. Possible fertility referral for ovulation support
2. Hair/skin may need an endocrine/dermatologist referral
3. Endometrial protection and periods - IUS or cyclical progestogens to ensure 3-4 withdrawal bleeds per year to prevent hyperplasia
4. Weight loss
5. Combined Oral Contraceptive Pills - androgen side effect and endometrial protection
6. Metformin alone – not recommended - limited evidence (NICE)

Increased risk of:

- poor self esteem
- depression
- CVD/ metabolic syndrome
- fertility issues
- sleep apnoea
- poor reproductive outcomes
- diabetes
- non-alcoholic fatty liver
- endometrial cancer

Resources

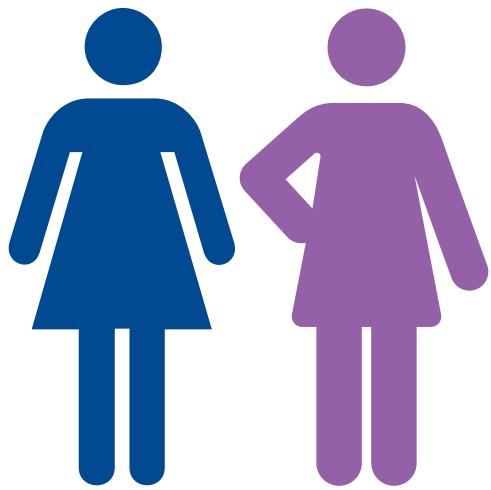
ESHRE (2018) (PCOS) www.eshre.eu/Guidelines-and-Legal/Guidelines/Polycystic-Ovary-Syndrome.aspx
Verity, a charity for women www.verity-pcos.org.uk

Pre-menstrual Syndrome (PMS)

A chronic cyclical condition, with multiple symptoms that occurs in the luteal phase (second half) of the menstrual cycle. 40% of women experience PMS symptoms and of these 5-8% will suffer severe PMS.

Symptoms may be psychological and physical

- Depression and anxiety
- Loss of confidence
- Mood swings
- Food cravings
- Irritability
- Mastalgia
- Bloating
- Change in sleep pattern



Cause

Causes of PMS is not known but some women have progesterone sensitivity, this may be due to a reduction in the neurotransmitters serotonin and gamma-aminobutyric acid.

Diagnosis and management

A PMS diagnosis is dependent on the timing of symptoms rather than the character of the symptoms. The degree of impact on the woman's daily life must be considered and the symptoms should cause significant impairment during the luteal phase of the menstrual cycle (before period) to establish a diagnosis. Symptoms should resolve within a few days of menstruation commencing. A symptom diary should be used prospectively for at least two cycles.

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Pre-menstrual Syndrome (PMS)

Treatments

Lifestyle changes - exercise and reducing caffeine, alcohol, salt, sugar and simple carbohydrates.

1st line treatments include combined oral contraceptive pill (COC), Vitamin B6 or low dose selective serotonin reuptake inhibitor (SSRIs) antidepressants and cognitive behavioural therapy. Drospirenone-containing COC should be considered as a first line pharmacological intervention and should be used continuously rather than cyclically.

2nd line treatments include estradiol patches with micronized progesterone or Levonorgestrel intrauterine system, or higher dose SSRIs.

3rd line includes gonadotropin-releasing hormone analogues with add-back hormone replacement therapy (HRT) (continuous combined).

4th line surgical treatment +/-HRT.

Resources

National Association for Pre-menstrual syndrome
www.pms.org.uk

RCOG (2016) Green top guideline No 48 Management of Pre-menstrual syndrome www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg48/

RCN (2016) Woman's Health Pocket Guide Part 1, p.3. www.rcn.org.uk/professional-development/publications/pub-005855

Pelvic Organ Prolapse

- Affects 50% of parous women.
- Risk of prolapse doubles with each completed decade of life.

Type - main types
Cystocele – anterior wall
Rectocele – posterior wall
Uterine – womb
Vault prolapse – post hysterectomy
Enterocele – small bowel
Urethrocele

Symptoms
Dragging sensation
Difficulty emptying bowels and bladder
Sitting on an egg type feeling
Backache
Feeling something come down or out of the vagina

The RCOG Patient information leaflet has useful diagrams.

Risk factors

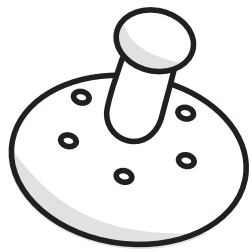
- Chronic constipation – straining
- Chronic cough
- Childbirth and pregnancy
- Family history – increased risk if mother/aunt had a prolapse
- Hysterectomy – vault prolapse, cystocele, rectocele
- High impact exercise – trampolining, running

Treatments

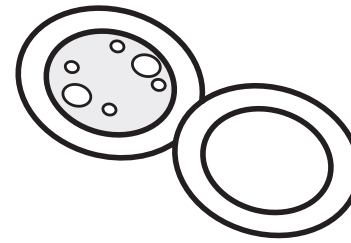
- Pelvic floor exercises – don't cure prolapse, strengthen the muscle to help relieve symptoms
- Pessary – different types. Use whilst waiting for surgery, whilst family not complete, if surgery not suitable
- Surgery – hysterectomy, anterior/posterior repair, sacrospinous fixation, 30% recurrence rate following surgery

Pelvic Organ Prolapse

Pessaries
Many different types for different prolapses. Ring and gelhorn most commonly used.



Gelhorn



Ring

Changing the pessaries

- 4-6 monthly
- Can notice increased vaginal discharge
- Observe vaginal tissue quality with speculum
- If bleeding or ulceration – leave pessary out and treat with topical vaginal oestrogens, replace pessary after one month
- If tissues atrophic consider low dose topical vaginal oestrogen such as vagifem, twice weekly
- If any post-menopausal bleeding – refer to rapid access clinic for ultrasound scan to check endometrial thickness
- Self-management – option for dexterous women, remove, wash and replace as needed
- May not always find correct size at first fitting

Resources

RCOG (2018) Menopause and women's health in later life www.rcog.org.uk/en/patients/menopause/pelvic-organ-prolapse

RCOG (2018) Patient information leaflets www.rcog.org.uk/en/patients/patient-leaflets/pelvic-organ-prolapse

Pelvic Floor Exercises (PFE)

Stronger pelvic floor muscles help to reduce symptoms of stress incontinence and an overactive bladder.

Pelvic floor exercises strengthen the muscles around the bladder, vagina, and anus.

It is essential that women know which muscles to contract - vaginal examination assessing squeeze.

Regularity is key - ideally needs to be three times a day. Maintenance – once daily.

Using a Valsalva manoeuvre (push down) will make pelvic floor weaker.

How to do the exercises

- PFE can be done lying, sitting or standing. Lying is easiest, standing most difficult
- Squeeze the muscle as if trying to stop the flow of urine and as if trying to stop passing wind
- Squeeze up, NOT push down
- Fast contractions – aim for 10 repetitions
- Slow contractions – aim for 10 repetitions, holding for 10 seconds – do less if this feels too much
- Relax muscle fully in between contractions, do not use the stomach muscle
- To check – woman can put finger in vagina to feel a squeeze, or finger on perineum to feel a lift
- Any push down is not advised
- Do not encourage women to stop the flow of urine, this can create issues with voiding and possible reflux, and is now considered outdated

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Pelvic Floor Exercises (PFE)

Devices

Many different types for different prolapses. Ring and gelhorn most commonly used.

- Electrical stimulation machines. For those with little or no contraction
- Intra vaginal supports (more popular since suspension of mesh procedures) – ring with knob, diveen, uresta, contiform, incostress
- Squeezy app from app store- will provide reminder to do the exercises regularly
- Elvie personal trainer – biofeedback device – available on NHS

Referral to

Women's health physiotherapist or urogynaecology Clinical Nurse Special for assessment if not sure technique is correct.

Resources

NICE (2013) *Urinary incontinence in women: management* www.nice.org.uk/guidance/CG171

Tommys (2018) *Pelvic floor exercises* www.tommys.org/pregnancy-information/im-pregnant/exercise-pregnancy/pelvic-floor-exercises

NHS Choices (2018) *What are pelvic floor exercises?* www.nhs.uk/common-health-questions/womens-health/what-are-pelvic-floor-exercises

Benign Vulval Disorders

The vulva is the external female sex organs and includes the urethral opening and anus. There are a wide range of conditions that can cause symptoms, but the common ones are listed below.

Symptoms

- Itching – most common presenting symptom
- Pain – including soreness, discomfort and dyspareunia
- Discharge
- Change in appearance – including colour change or loss of anatomy
- Presence of a lump/lesion

Conditions	
Lichen sclerosus (LS) is an inflammatory dermatosis of unknown cause	Symptoms include itching, irritation and white patches on the vulva
Lichen planus (LP) is an inflammatory disorder with manifestations on the skin, genital and oral mucous membranes	Symptoms include soreness, itching and dyspareunia
Vulval dermatitis (also known as eczema) refers to itchy inflamed skin usually due to irritants on the skin e.g. urine, scented wipes.	Symptoms include soreness and itching. On examination the skin may be inflamed, swollen, weepy and excoriated
Vulvodynia is a disorder of chronic vulval pain (neuropathic) in the absence of any obvious skin condition or infection	Pain frequently felt at the introitus when touched during sexual intercourse or on insertion of tampons. Sometimes pain may be spontaneous. The vulva looks normal.

Benign Vulval Disorders

Diagnosis and management

The majority of benign vulval disorders can be diagnosed with a detailed history and full examination of the vulva. A biopsy may be taken if a lesion is present. Women should be given a diagnosis, information about their condition and basic skin care (e.g. avoidance of irritants).

Incidence

Currently the incidence of many vulval disorders in the UK is unknown but LS is estimated to affect up to 3% of adult females.

Treatments

Topical treatments include topical steroids, antiseptics, antibacterials and antifungals. For symptomatic patients, emollients (to keep skin hydrated and to act as a barrier) and good skincare (avoiding wet wipes, talcum powder, urine) will benefit many.

For LS and dermatitis effective treatment is with the regular, appropriate application of strong steriod ointments (to suppress skin inflammation such as clobetasol propionate). Steriod thinning is uncommon.

Vulvodynia patients may need a holistic approach. Cognitive behavioural therapy, psychosexual counselling, perineal massage, pelvic floor muscle physiotherapy, topical lidocaine and oral neuromodulators such as amitriptyline or pregabalin may help.

Resources

Vulval Pain Society www.vulvalpainsociety.org
British Society for the Study of Vulval Disease www.bssvd.org
Association for Lichen Sclerosus and Vulval Health
www.lichensclerosus.org

Supported by Vulval Pain Society

Cancer of the Endometrium

Abnormal tissue growth within the endometrium.

5th most common female cancer, with 6,400 new cases annually in the UK.

Causes/Risks	Signs and Symptoms
• Extended exposure to oestrogen (early menarche, late menopause) • Obesity • Genetic factors such as Lynch syndrome • Polycystic ovarian syndrome • Diabetes • Infertility • Nulliparity • Hypertension • Having unopposed oestrogen and Tamoxifen	• Postmenopausal bleeding • Post-coital bleeding • Intermenstrual bleeding • Change in menstrual pattern • Pelvic pain • Dyspareunia

Diagnosis	Types
Investigations including: pelvic examination, ultrasound scan, an endometrial biopsy or a hysteroscopy and biopsy	• Endometrioid adenocarcinoma (most common) • Mucinous adenocarcinoma • Serous adenocarcinoma • Clear cell adenocarcinoma • Undifferentiated carcinoma (large/ small cell types) • Carcinosarcoma • Squamous adenocarcinoma • Mixed carcinoma • Metastatic carcinoma

Diagnosis is confirmed following a biopsy result, which will provide the grade of the cancer, a MRI and CT will be organised to ascertain the stage of the disease in order to plan treatment with the multidisciplinary team.

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Cancer of the Endometrium

Treatments

Treatment for early stage endometrial cancer involves surgery, laparoscopically or open.

Surgery: Total hysterectomy
+/-bilateral salpingo oophorectomy
+/- bilateral pelvic lymph node dissection
+/- para-aortic lymph node dissection
+/- omentectomy

Women with more advanced disease may be offered further treatment after surgery:

- External beam radiotherapy
- Internal brachytherapy
- Chemotherapy

Women with recurrent and metastatic disease can be treated with hormones or palliative radiotherapy to control their symptoms.

Side effects of treatment

- Lymphoedema
- Induced menopause
- Late gastrointestinal effects on bowel +/- bladder
- Vaginal stenosis
- Shortened vagina
- Body image/sexual issues
- Loss of fertility
- Peripheral neuropathy
- Fatigue

Resources

MacMillian (2017) www.macmillan.org.uk
Cancer Research UK www.cancerresearchuk.org
Eve Appeal https://eveappeal.org.uk
Gynae-C www.canceradvice.co.uk/support-groups/gynae-c

Cancer of the Ovary

One of the most common types of cancer, late diagnosis amongst women.

Causes/Risks	Signs and Symptoms
Age – risk increases after the menopause	Feeling bloated/abdominal distention
Hormonal Factors – early menarche, later menopause and HRT	Persistent pelvic and abdominal pain
Family History and Genetic Mutation – two or more close relatives who have had ovarian cancer or certain other types	Feeling full quickly after eating
Physical Factors – Height, endometriosis and ovarian cysts	Loss of appetite
Lifestyle Factors – smoking, weight and diet	Changes in bowel habits or urinary symptoms Pain during sex Weight loss Fatigue

Diagnosis

Examination, CA125 (blood tumour marker), ultrasound scan, CT, ascitic fluid aspiration, image guided biopsy, surgery.

Treatment plans are made in a multi-disciplinary setting (MDT) depending on the stage/grade/ type.

Types

- Serous (most common)
- Clear cell
- Teratoma
- Mucinous
- Undifferentiated
- Granulosa Cell Tumour (GCT)

Cancer of the Ovary

Similar Cancers - primary peritoneal and fallopian tube cancer are diagnosed and treated similarly to ovarian cancer.

Treatments

Early stage cancers

Borderline tumours or early stage ovarian cancer can usually be cured with surgery.

Early stage clear cell, high grade serous or stage 1c are usually offered chemotherapy after surgery (adjuvant).

Some women with early stage disease may be offered fertility sparing surgery.

Advanced Ovarian Cancer

Treated with surgery and chemotherapy, this can be pre or post-surgery. Chemotherapy may be the main treatment used to palliate and control symptoms.

Surgery usually involves: Total Abdominal Hysterectomy, with Bilateral Salpingo-oophorectomy, and Bilateral Pelvic and para aortic Lymphadenectomy, and Omentectomy, +/- Bowel resection (in some cases).

Resources

RCOG (2016) *Patient Information leaflet on Ovarian cancer* www.rcog.org.uk/en/patients/patient-leaflets/ovarian-cancer

NICE (2011) *Ovarian cancer: recognition and initial management* www.nice.org.uk/Guidance/Cg122

Ectopic Pregnancy

An ectopic pregnancy is one that develops outside of the uterus; commonly in the fallopian tube.

Incidence – 1 in 80 pregnancies, and is a leading cause of death in early pregnancy.

Risk factors

- Previous ectopic pregnancy – 10% chance of subsequent ectopic
- Fertility treatment
- Pelvic inflammatory disease or chlamydia
- Abdominal or tubal surgery
- Endometriosis
- Smoking
- Increased risk following contraceptive failure with progestogen-only pills and intrauterine devices
- A third have no known risk factors

Symptoms

- May occur from 4-12 weeks gestation or later
- Vary and can resemble other conditions, e.g. gastrointestinal conditions, miscarriage, UTI

Key symptoms

- Missed/late period
- Abdominal/pelvic pain
- Bladder/bowel problems
- Shock or collapse
- Vaginal bleeding
- Shoulder tip pain
- Usually a positive pregnancy test

Diagnosis

- Clinical assessment
- Trans-vaginal ultrasound scan
- Serum human chorionic gonadotropin (hCG) levels

Ectopic Pregnancy

Treatment is dependent on clinical presentation and hCG level:

- Surgical management
- Medical management with Methotrexate
- Expectant management (active monitoring)

Anti-D prophylaxis for rhesus negative women who have a surgical procedure.

Future considerations

- Avoid conception for two menstrual cycles after treatment
- Women treated with Methotrexate should wait until hCG level <5mIU/mL, then take folic acid for 12 weeks before trying to conceive
- Women to be scanned at six weeks gestation in future pregnancies
- Consider the need for emotional support
- Signpost women to the Ectopic Pregnancy Trust for information and support

Resources

Ectopic Pregnancy Trust www.ectopic.org.uk
Association of Early Pregnancy Units www.aepu.org.uk
NICE (2012) *Ectopic pregnancy and miscarriage: diagnosis and initial management* www.nice.org.uk/guidance/cg154
RCOG (2016) *Diagnosis and Management of Ectopic Pregnancy* (Green-top Guideline No. 21) www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg21/
RCOG (2016) *Ectopic Pregnancy* www.rcog.org.uk/en/patients/patient-leaflets/ectopic-pregnancy/

Supported by The Ectopic Pregnancy Trust
Registered Charity No. 1071811

Gestational Trophoblastic Disease (GTD)

GTD (previously called molar pregnancy or hydatidiform mole) is an abnormal development of the trophoblast layer of the placenta (approximately 1 in 600 women). Women diagnosed with GTD need follow-up as there is a risk that the condition progresses to Gestational Trophoblastic Neoplasia (GTN).

Types

- Complete hydatidiform mole - genetically abnormal pregnancy; no fetus develops (1:1000). 15% progress to GTN
- Partial hydatidiform mole - genetically abnormal pregnancy; abnormal fetus starts to form but unlikely to survive (3:1000). 0.5% progress to GTN
- Invasive - trophoblastic cells occurs when a molar pregnancy invades into the myometrium.
- Choriocarcinoma malignant disease, 50% occur after a molar pregnancy
- Placental site trophoblastic tumour malignant disease - very rare; occurs more commonly after non-molar pregnancies

Risk Factors

- Age - more common in teenage women and women over 45
- Ethnicity – twice as common in women of Asian origin
- Previous GTD – 1 in 80 chance of another GTD episode

Symptoms

- Vaginal bleeding (80%)
- Hyperemesis (10%)
- Uterine enlargement (25%)
- Hypertension (1%)
- No symptoms presenting at the first booking appointment

Detection

- Overall Detection rate via ultrasound is 44%
- 90% of complete moles are diagnosed on ultrasound scan compared to 30% of partial moles
- Histopathology diagnosis required in all cases as other methods are unreliable

Gestational Trophoblastic Disease (GTD)

Management

Suspected GTD

↓

Surgical management only
(Anti D prophylaxis if Rhesus negative)

↓

Histology

↓

GTD diagnosed

↓

Refer to Regional Trophoblastic Disease Centre (RTDC)

Reproductive Considerations

- Women await RTDC discharge instructions – once clear it is safe to try for another pregnancy
- Barrier methods of contraception advised until safe to conceive
- Some women may require RTDC follow-up post any subsequent pregnancies, independent of pregnancy outcome

Resources

Association of Early Pregnancy Units www.aepu.org.uk

Sheffield Trophoblastic Disease Centre
http://stdc.group.shef.ac.uk

RCOG (2010) Gestational Trophoblastic Disease (Green-top Guideline No. 38) www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg38

Supported by ASSOCIATION OF EARLY PREGNANCY UNITS

Ovarian Cysts

Cysts are seen on ultrasound and vary in size, they can be fluid filled (simple) or be solid and contain solid material, blood or have compartments (complex).

Types

Functional

- Corpus luteal: 2-3 cm fluid filled sac. An egg is released at ovulation forming a corpus luteum.
- Functional ovarian cysts: follicle doesn't rupture to release the egg. They are usually large, asymptomatic and resolve without treatment.

Non Functional

- Haemorrhagic cysts - bleeding within the follicular cyst. A rescan in 4-6 weeks should ensure it's resolved.
- An endometrioma - 'chocolate cysts' filled with old blood. They cause significant pain and don't resolve without treatment (see *endometriosis*)
- Benign germ cell tumours 'dermoid' cysts - contain hair, bone and fat and as they develop in size they are associated with a risk of torsion. Usually occur in young women with a 2-3% risk of malignancy.

Signs and symptoms

- Symptomatic or asymptomatic
- Unilateral or bilateral dull, sharp, constant or intermittent pain
- Sudden severe sharp pain if rupturing
- Severe pain along with vomiting if torsion

Ovarian Cysts

Investigations

- Vaginal and bimanual examination
- A transvaginal ultrasound scan
- Consider a pregnancy test
- CA 125 (blood test – tumour marker) in postmenopausal women or if malignancy suspected

Treatment

Premenopausal women:

- <5cm – treatment is not needed
- 5 – 7 cm – ultrasound follow up
- A simple cyst of 7cm – further imaging, MRI +/- surgery

Postmenopausal women:

- rescan in 4-6 months if <5cm
- surgery recommended for ovarian cysts >5cm

Resources

RCOG (2016) The management of ovarian cysts in postmenopausal women. Green top guideline 34 www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg34

RCOG (2012) Patient information leaflet - Ovarian cysts before the menopause www.rcog.org.uk/en/patients/patient-leaflets/ovarian-cysts-before-the-menopause

Women and Mental wellbeing

Women are twice as likely as men to be diagnosed with a mental health problem.

53% of women who have mental ill-health have experienced violence/abuse or post traumatic distress syndrome (affects over 31% of population).

Impacts on mental well-being include:

- feelings, thoughts and actions
- physical health, wellness and experiences
- education and employment
- social/family relationships
- economic and social circumstances
- lifestyle choices
- culture and ethnic background
- gender and sexuality
- use of drugs or alcohol
- past experiences
- any dependents e.g. a child or elderly relative

Types

- Generalised anxiety disorder (GAD), social anxiety, panic disorder, obsessive-compulsive disorder (OCD)
- Severe mental health problems include:
  - depression
  - psychosis and bipolar disorders
  - autistic spectrum disorders
  - personality disorders
  - attention deficit hyperactivity disorder
- Suicide and self-harm
- Perinatal mental health (PMH) - mental health during pregnancy and the first postnatal year. Characterised by an existing mental health issue or a condition that arises during pregnancy:
  - antenatal depression
  - postpartum:
    - maternity blues, affects 80%
    - postnatal depression, affects 10%
    - puerperal psychosis, rare but severe psychiatric illness

Women and Mental wellbeing

As you enquire 'how are you feeling? Consider asking the following supplementary questions:

- Do you take time to look after yourself?
- How are you coping?
- Do you feel low?
- Are you sleeping poorly?
- Are you not eating properly?
- Are you tearful, angry and/or anxious?
- Do you have concerns about your mental health?
- Do you have anyone to talk to about your concerns and what impact is this having?

This should lead to a diagnosis of mental wellbeing as well as physical health.

IDENTIFY > DIAGNOSE > EARLY INTERVENTION > APPROPRIATE CARE > AFTER CARE

Resources

Mental Health Foundation (2017) *Fundamental Facts about mental health 2016* www.mentalhealth.org.uk/publications/fundamental-facts-about-mental-health-2016

Agenda www.weareagenda.org (Women in Mind campaign)

NICE Mental health and wellbeing www.nice.org.uk/guidance/lifestyle-and-wellbeing/mental-health-and-wellbeing

Rethink www.rethink.org

Young Minds www.youngminds.org.uk

Amenorrhoea

Types of amenorrhoea

Primary amenorrhoea (0.3%) failure to establish menstruation

- by 16 years of age with normal secondary sexual characteristics
- Pathological causes: genito-urinary malformation or androgen insensitivity syndrome (AIS)
- by 14 years with no secondary sexual characteristics
- Pathological causes: Turner's syndrome or hypothalamic-pituitary dysfunction
- Other causes: pregnancy or constitutional growth delay (BMI below 19)

Secondary amenorrhoea (3%) absence of menstruation for six months or more after previously normal regular periods.

Causes

- polycystic ovarian syndrome (28%)
- premature ovarian insufficiency (12%)
- hypothalamic amenorrhoea (34%)
- hyperprolactinaemia (14%)
- pregnancy
- anatomical factors (7%)

Investigations

- clinical history
- imaging
- follicle stimulating hormone and luteinising hormone
- oestradiol
- physical examination
- thyroid function
- prolactin
- androgen concentration

Treatments

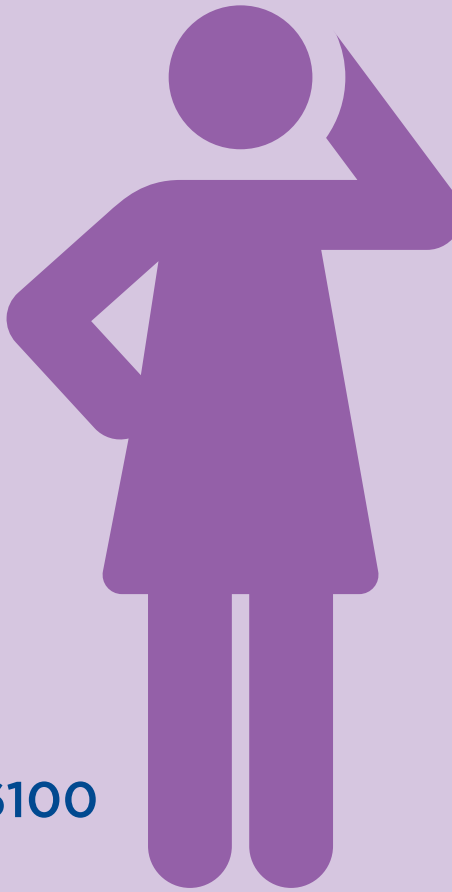
- Most girls with primary amenorrhoea will be referred to secondary care
- For secondary amenorrhoea treat as per diagnosis and refer as required.
- Refer if the woman is concerned about fertility

Resources

NICE (2014) Amenorrhoea https://cks.nice.org.uk/amenorrhoea

Royal College of Nursing

Keep in touch



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