Gynaecology for primary health care workers

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Gynaecology is often very confusing for primary care health workers

- **Syndromic algorithms are not so easy to design, and need to be adapted to local circumstances**

- **Lack of standard treatment schedules and primary care manuals means that women often miss out on reasonable care for their gynaecological problems especially in rural areas**

If normal fertility spontaneously ceases in the fertile age group it is probably a serious gynaecological condition

- Fact of normal Life: Normal cycle, plus partner (without FP) = pregnancy
- If a 'partnered' woman presents with LAP and she is having regular periods (ie she is ovulating), and has not become pregnant within a year or two, she probably has PID or Endometriosis
- If a woman has previously not had a problem getting pregnant, and subsequently (with out any use of FP) is now unable to get pregnant, she has PID (or endometriosis) until proven otherwise

Example cases

- **Aged 26, a few boyfriends as a youngster, married for the past 5 years, unable to get pregnant (semen test OK), +/- recurrent LAP = chronic PID**

- **Aged 27, para 1, 5 years ago; unable to get pregnant again, +/- recurrent LAP = chronic PID**

Endometriosis is much less common cause of subfertility than PID in the Pacific because of the high prevalence of STIs – especially Chlamydia and Gonorrhoea

Primary management plan for above cases: 'probably PID'

- **Doxycycline 100mg bd (after food) for 10 days, plus Metronidazole 400mg tds for 5 days (or Tinidazole 1g bd for 3 days)**
- **Consider HIV and Syphilis serology testing (PICT)**
- **Analgesics: especially before and during periods (eg. Paracetamol 1g tds plus NSAID – eg. Diclofenac 50mg tds or Ibuprofen 400mg tds)**
- **Consider referral if no response to the above treatment OR if there are symptoms or signs of suggestive Endometriosis, give a trial of Endometriosis treatment**

Endometriosis differential: dysmenorrhoea, dyspareunia and subfertility are common to PID

- **Dysmenorrhoea: for PID the LAP/backache commences 1-5 days before the onset of the menses, but the pain subsides on the 2nd day of the menstrual flow**

With Endometriosis; the dysmenorrheoa does not subside on the 2nd day of the menstrual flow, but persists until the end of the flow

- **Post menstrual brown spotting is almost diagnostic (ie specific) for Endometriosis – although it is not a very sensitive symptom for the diagnosis (ie many women with Endometriosis do not have this symptom)**
- **Many endometriosis patients get a variety of 'constitutional symptoms' at the time of their menses: eg. dysuria, malaise, fever, GI symptoms, headaches, dizziness etc.**
- **Usually no social history suggestive of STIs (as there is for PID)**

Primary care management of "? Endometriosis"

- **OCP or Depoprovera for 12 months to 'put the ovaries to sleep'; this stops the high concentration oestrogenic stimulation of the endometriosis tissues on the pelvic peritoneum**
- **Depoprovera 300mg imi stat and 150mg every 3 months for 12 months, or**
- **OCP daily for 12months**
- **Paracetamol and NSAID for pelvic pain prn**

- **Refer to gynaecologist for assessment and further management if does not respond**

Abnormal PV bleeding

- Presents with heavy PV bleeding and clots and cramping LAP
- Is it a miscarriage or is it an episode of DUB??

- Miscarriage: previously regular cycles, then misses a period, develops early pregnancy symptoms (frequency, breast tenderness and ? nausea) – followed by the heavy bleeding, passage of clots and cramping LAP: the cervix is softened and the os is open
- **DUB:** Previously irregular cycles, often misses out a month or two, now has missed out several months (but no symptoms of early pregnancy) and commenced bleeding with clots and cramping LAP (spasmodic dysmenorrhoea): cervix is firm and closed

Chronically **DUB** women are often obese, may have PCOS and subfertility. May say that they have had many miscarriages when in fact they have never been pregnant: all the bleeding episodes were DUB

Management plan for recurrent DUB

- **Norethisterone 10mg every 2 hours until the bleeding slows to spotting only: average time for high dose Norethisterone to arrest DUB is 3-4 doses.**
- **Then Norethisterone 10mg daily for 12 days**
- **Inform the women to expect a 'normal period' when she completes her 2 weeks of Norethisterone.**
- **After that regulate cycle with OCP for 3-6months**
- **Arrange for a diagnostic D&C is she is over 40 years, in case there is endometrial hyperplasia or cancer of the endometrium starting.**

Abnormal PV bleeding continued

- **Any woman with abnormal PV bleeding; especially irregular bleeding, inter-menstrual bleeding, post-coital bleeding or bleeding associated with a bad vaginal odour should have a speculum examination to look for Cancer of the Cervix**

- **Unfortunately, the challenge with Cancer cervix diagnosis in the PICs is that we are not able to do anything curative beyond stage 1 disease. And palliative care is also difficult without regular supplies of oral Morphine**

Vaginal discharge: some issues

- **There is very often NO abnormal vaginal discharge associated with chronic PID**
- **Many women complain of vaginal discharge when in fact they have no pathological discharge: this is a big challenge for the health worker who needs to be expert in telling the difference between physiological and pathological vaginal discharges**
- **Many women with non-STI vaginal discharges due to vaginitis end up in STI clinics and get all sorts of STI treatments. Vaginitis is not caused by STIs.**

Vaginal discharge: how to approach the patient and management plan

- **Presenting symptom of vaginal discharge usually means that the woman is worried about a serious pelvic disease like cancer or STI and wants you to examine her carefully (speculum examination).**

- **If the discharge is white, lumpy and itchy it is likely to be Monilia – do not give antibiotics, treat locally with chlotrimazole or miconazole vaginal tabs**
- **If the discharge is watery and frothy (bubbles in it), it is probably trichamonas- treat with Flagyl or Tinidazole orally**
- **If the discharge is grey-white and smells bad, it is probably Bacterial vaginosis – treat with Flagyl or Tinidazole orally**

"Vaginal discharge": discharge looks normal-physiological on speculum exam

- **This is often the case. Don't just say, "don't worry everything looks normal", and send her away**

- **This woman is worried about a vaginal problem; sometimes her actual concern is 'infertility', or concern about "STI" (unfaithful husband)**
- **You must address the woman's actual problem - so ask her what is the real reason for coming to see you today**
- **Many women complaining of vaginal discharge are worried about cancer or STIs.**

By following some simple rules, Primary Carers can provide effective and beneficial care for Gyn symptom presentations.