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**Chronic Pelvic Pain**

**Contraceptive counselling**
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- IUD
- Implanon
- Terminations of pregnancy

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- Pelvic Inflammatory disease
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- Incontinence
- Urodynamics

**Reproductive Medicine**
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- Recurrent miscarriages
- Tubal & vasectomy reversal
- Endocrine problems (Polycystic Ovarian Syndrome)

**Sexual Medicine and Therapy Clinic**
- Sexual & relationship counselling

**Services not provided**
- In Vitro Fertilisation

**PLEASE NOTE:** All referrals received by Monash Health are triaged by clinicians to determine urgency of referral.

- Patients assessed as having an **urgent** need are offered an appointment within thirty days as assessed by the clinician.
- Patients assessed as having a **non-urgent** need for appointments in clinics where there is no waiting list, are offered an appointments within four months on a “treat in turn basis”.
- Patients assessed as having a **non-urgent** need for appointments in clinics that have a waiting list, referrers and patients will be notified of the expected wait times. Where the wait time does not meet patient needs, alternative service providers can be found by searching the Human Services Directory at [http://humanservicesdirectory.vic.gov.au/Search.aspx](http://humanservicesdirectory.vic.gov.au/Search.aspx)
### Adolescent Gynaecology

**Patient Presentation**

Any gynaecological problem in a girl or young lady 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
- If signs of increased androgen then DHEAS, FAI, SHBG
- If ovarian cysts then consider the tumour markers, most importantly Ca125

**WHEN TO REFER**

- 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)

---

### Chronic Pelvic Pain

**Patient Presentation**

- Chronic Pelvic Pain

**Initial GP Work Up**

- Try to find out if gynaecological or bowel. Take a history on bowel habit to rule out constipation as a cause. Try to illicit if irritable bowel syndrome is the problem

**Management Options For GP**

- Pelvic Ultrasound

**WHEN TO REFER**

- If diagnosis is uncertain
## Contraceptive Counselling

<table>
<thead>
<tr>
<th>Patient Presentation</th>
<th>Initial GP Work Up</th>
<th>Management Options For GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sterilisation</td>
<td>Nil</td>
<td>N/A</td>
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### WHEN TO REFER
- For procedure

<table>
<thead>
<tr>
<th>Patient Presentation</th>
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</thead>
<tbody>
<tr>
<td>Intra Uterine Device</td>
<td>Nil</td>
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### WHEN TO REFER
- For insertion

<table>
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<tr>
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<tbody>
<tr>
<td>Implanon</td>
<td>Nil</td>
<td>N/A</td>
</tr>
</tbody>
</table>

### WHEN TO REFER
- For insertion

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Contraceptive Counselling cont...

Patient Presentation
- Terminations of pregnancy

Initial GP Work Up
- If dates uncertain, pelvic ultrasound

Management Options For GP
- 

WHEN TO REFER
- For procedure

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Dysplasia

Patient Presentation
- Abnormal PAP smear

Initial GP Work Up
- An up to date pap smear
- Consider using Oestrogen cream and or a thin prep in post-menopausal patients
- STD screen and vaginal/cervical swabs where appropriate
- History of previous abnormal pap smears
- Sexual history/recent change of partner
- HPV vaccination history
- History of IMB, PCB, PMB or watery discharge

Management Options For GP
- Repeat pap smear as per Guidelines for the Management of Asymptomatic women with screen detected abnormalities
- Consider using Oestrogen cream and or a thin prep in post-menopausal patients
- Ultrasound in cases of PMB, IMB
- Pap smear in all cases of PMB
- Exclude and treat STD’s

WHEN TO REFER
- In cases of frank malignancy ring the Gynae-Oncology Unit
- Urgent referral for pregnant patients, a suspicious cervix ie appearance of malignancy, all high grade abnormalities, abnormal glandular cells on pap smear. PCB in the older woman ie 40 yrs

Patient Presentation
- 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 STD screen
- Bloods for serology as appropriate ie 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

WHEN TO REFER
- Urgent referral for ulcers in menopausal patients, any ulcer that has not responded to a short course of emollients or a mild steroid cream
Dysplasia cont...

Patient Presentation
- Vulval disorders

Initial GP Work Up
- History of complaint
- Associated factors ie Candida
- Age of patient
- Symptoms of discharge or systemic illness, chronic disease
- Presence of extensive leukoplakia

Management Options For GP
- Swabs
- General blood tests ie FBC
- Use of mild topical cortisone cream for a short period may be appropriate
- Treat candida-vaginally and topically
- Avoid soap and shower gels

WHEN TO REFER
- Urgent referral for ulceration or a patient unresponsive to a short course of mild cortisone cream, menopausal patients with a history of chronic itching, a patient with a co-existent abnormal pap smear or when Lichen Sclerosus is suspected

---

Patient Presentation
- Genital warts

Initial GP Work Up
- History of appearance
- Sexual; history, change of partner
- Pap smear history
- History of smoking/immunosuppression

Management Options For GP
- Pap smear
- STD screen
- Counselling
- Use of topical agents such as Aldara or Podophyllin

WHEN TO REFER
- Urgent referral for extensive genital warts or warts unresponsive to a short course of local treatment, warts present in vagina or on cervix

---

Endometriosis

Patient Presentation
- Pelvic pain with symptoms suggestive of endometriosis

Initial GP Work Up
Pelvic ultrasound

Management Options For GP
- Refer

WHEN TO REFER
- For diagnosis and management
### Gynaecology Endoscopy

**Patient Presentation**
- Ovarian Cysts

**Initial GP Work Up**
- **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) Ultrasound scan (specialist experienced in Gynaecological Ultrasound)
  - (c) Tumour Markers (CA 125, Ca 19.3, AFP, CEA, hCG, LDH, Inhibin)

- If 5cm +/- size, repeat scan after menstrual period when applicable (can exclude such as corpus luteal cysts)

- 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.

**Management Options For GP**

**WHEN TO REFER**
- Symptomatic: Refer urgently if persistent or colicky pain, weight loss, anaemia, any suspicion of ascites or irregularly contoured mass on abdominal or pelvic examination.
- Asymptomatic: Refer as soon as possible.

---

**Patient Presentation**
- Dyspareunia

**Initial GP Work Up**
- Superficial or Deep
- If superficial consider vaginismus and referral to Sexual Medicine and Therapy clinic (previously SARC)
- Ultrasound if deep

**Management Options For GP**
- If superficial make sure that patient does not have a vaginal infection especially if recent onset.

**WHEN TO REFER**
- Asymptomatic: Refer as soon as possible.

---

**Patient Presentation**
- Fibroids

**Initial GP Work Up**
- Ultrasound

**Management Options For GP**
- Nil

**WHEN TO REFER**
- Asymptomatic: Refer as soon as possible.
Patient Presentation
- Acute Pelvic Inflammatory Disease
  - Symptomatology – pain, discharge, pyrexia
  - Out of phase bleeding
  - ? presence of IUCD
  - Investigations
    - FBC/ESR
    - HVS/Chlamydia smear/swabs
    - Urine specimen –Chlamydia
    - Endocx/urethral/rectal swab
    - HCG
    - ?Smear

- Chronic Pelvic Inflammatory Disease
  - Symptomatology – chronic pain, discharge, erratic bleeding, recurrent episodes of acute PID, dyspareunia
  - Investigations
    - See acute
    - Ultrasound scan

Initial GP Work Up
- Acute Pelvic Inflammatory Disease
- Chronic Pelvic Inflammatory Disease

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)

WHEN TO REFER
- Acute PID: Acutely unwell, pelvic mass, unresponsive to treatment (12-16 hours). Refer for admission
- Positive pregnancy test with pelvic pain +/- fever (consider abortion). Refer for admission
- Chronic PID: Unresponsive to treatment

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### Gynaecology Oncology

<table>
<thead>
<tr>
<th>Patient Presentation</th>
<th>Initial GP Work Up</th>
<th>Management Options For GP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer of the cervix</td>
<td>FBE, UEC if bleeding, Pap smear</td>
<td>Refer to gynaecology</td>
</tr>
</tbody>
</table>

**WHEN TO REFER**
- ASAP

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<tr>
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<tbody>
<tr>
<td>Ovarian cancer</td>
<td>CA125, CA19.9, CEA, Other tumour markers as per gynaecology team, Pelvic USS+/- CT (C/A/P), FBE, UEC</td>
<td>Refer to gynaecology</td>
</tr>
</tbody>
</table>

**WHEN TO REFER**
- ASAP

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</thead>
<tbody>
<tr>
<td>Gynae cancers – suspected and confirmed</td>
<td>FBE, UEC, Pelvic USS+/- CT, Pap smear</td>
<td>Refer to gynaecology</td>
</tr>
</tbody>
</table>

**WHEN TO REFER**
- ASAP

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Menopause

Patient Presentation
- Turner’s syndrome

Initial GP Work Up
- Previous information re history and diagnosis of Turners 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
- When is in transition from paediatric to adult long term follow up. New hormone therapy issues

Patient Presentation
- 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
- With onset of symptoms of menopause or prior to risk reduction surgery.

Patient Presentation
- Premature menopause
- Surgical menopause

Initial GP Work Up
- Two FSH/E2 levels at least 1 month apart if spontaneous menopause

Management Options For GP
- Refer Early Menopause Clinic

WHEN TO REFER
- With elevated FSH / symptoms of menopause under the age of 45 if spontaneous menopause. Preferably prior to surgery

Patient Presentation
- Menopausal problems with Complex medical or surgery problems

Initial GP Work Up
- Information about medical or surgical history

Management Options For GP
- Refer Menopause Clinic

WHEN TO REFER
- When complexity of medical or surgical issues impact on management of menopause symptoms

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Menstrual Management

Patient 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, eg pain, fatigue
- Family / personal history of haematological disorders
- Evidence of any genital tract abnormalities / abdominal mass
- Sexual history
- Ability to cope with bleeding, eg time off work

Investigations
- FBE / iron studies
- Thyroid function test
- PAP smear
- Pelvic ultrasound (especially if clinically undiagnosable pelvic mass)
- Pregnancy test

Management Options For GP
- Hormonal control, eg oral contraceptive / HRT
- Non steriodals, eg Mefenamic Acid 500 mgs TDS
- Treat anaemia (Hb<80g/l and low iron studies) for a minimum of 3 months
- Dietary advice
- Manage other abnormal investigations, eg hypo / hyper thyroidism

WHEN TO REFER
- Anaemia Hb < 80 g/l, Age > 37, Pelvic mass, Abnormal smear, Non response to other treatment modalities

Patient Presentation
- 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
- For cyst management

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Menstrual Management cont…

Patient Presentation
- Post menopausal bleeding
- (12 months from last menstrual period)

Initial GP Work Up
- Drug history (contraception, HRT particularly oestrogen only regimens)
- Evidence of any genital tract abnormalities, eg cervical polyps / atrophic change or abdominal mass
- Sexual / PID history

Investigations
- Smear
- HVS
- +/- pipelle
- Transvaginal Pelvic ultrasound
- Pregnancy test (unnecessary >55 years)

Management Options For GP
- Refer to specialist service – depending on ultrasound result
- Note: cervical polyps associated with post menopausal bleeding should be referred as frequently associated with sinister pathology

WHEN TO REFER
- Post-menopausal bleeding

- Post coital bleeding
  - Examine
  - Smear
  - HVS

- Support and counselling
  - Report further episodes
  - Encourage return if symptoms recur / change

WHEN TO REFER
- Recurrent, troublesome or embarrassing – refer to specialist service
Pelvic Floor / Urogynaecology

Patient Presentation
- 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
- Pelvic examination

Investigations
- MSU

Consider:
- FBC
- Biochemistry
- Renal 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)

WHEN TO REFER
- Symptomatic prolapse

NOTE: For patients with mild-moderate POP symptoms, 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)

Patient Presentation
- 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

WHEN TO REFER
- symptomatic or bothersome urinary or anal incontinence;
- symptomatic or bothersome urinary frequency, nocturia
- symptomatic or bothersome voiding difficulty, bladder pain,
- Recurrent UTIs; haematuria

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)

Patient Presentation
- Recurrent UTIs

Initial GP Work Up
- MSU
- Renal and bladder UST

Management Options For GP
- Vaginal estrogen
- Cranberry
- Hiprex and vit C
- Postcoital or low dose antibiotics

WHEN TO REFER
- symptomatic or bothersome urinary or anal incontinence;
- symptomatic or bothersome urinary frequency, nocturia
- symptomatic or bothersome voiding difficulty, bladder pain,
  Recurrent UTIs; haematuria
Patient Presentation

- Infertility

- Primary amenorrhoea

- Secondary amenorrhoea (> 6 months)

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

- Age > 15
- Weight history
- Dietary history
- 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

All of the above plus:

- Contraception history
- Drug history, eg psychotropic
- Galactorrhea
- Signs of masculinisation
- Hirsutism
- Significant stress and anxiety
- Environmental factors
- Past gynaecological history / surgery

Investigations

- HCG
- FSH/LH/E2/Prolactin x3*
- Testosterone / SHBG / DHEA (if hirsute)

Management Options For GP

- Specific treatments depend on specific problems identified as noted below
- Counselling and support
- Counselling and support

WHEN TO REFER

- Primary amenorrhoea – where there are abnormal results or significant patient stress / anxiety
- Secondary amenorrhoea – where there are abnormal results or significant patient stress / anxiety
### Reproductive Medicine cont…

<table>
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<tbody>
<tr>
<td><strong>Male infertility</strong></td>
<td>- Semen analysis (preferably at specialist lab such as Monash IVF).</td>
<td>- Lifestyle modification, in particular weight management, smoking and alcohol use.</td>
</tr>
</tbody>
</table>

**WHEN TO REFER**
- Immediately if no sperm present or severe changes on semen analysis. Otherwise after 6 months of infertility.

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<tbody>
<tr>
<td><strong>Recurrent miscarriages</strong></td>
<td>- Careful general and obstetric history</td>
<td>- Lifestyle modification, in particular weight management and smoking cessation.</td>
</tr>
</tbody>
</table>

**WHEN TO REFER**
- Generally, following 3rd miscarriage. After 2 miscarriages if maternal age > 38 or if additional history of infertility.

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</table>
| **Tubal & Vasectomy reversal** | - Basic fertility check of other partner  
- For tubal reversal:  
  - semen analysis  
- For vasectomy reversal:  
  - ovarian reserve: D2-5 AMH  
  - confirmation of ovulation: D21 progesterone | - N/A |

**WHEN TO REFER**
- Immediately

<table>
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</table>
| **Endocrine problems (polycystic ovarian syndrome)** | - TVUS  
- OGTT  
- FSH, LH, Prolactin, TSH  
- Testosterone, SHBG, Free androgen index | - Lifestyle changes, in particular weight management  
- OCP if not desiring pregnancy |

**WHEN TO REFER**
- Immediately - for management of troublesome irregular periods, especially when fewer than 6 periods per year.  
- Immediately - in the context of infertility
Sexual Medicine and Therapy Clinic

Patient 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 to vulval 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) PID 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 PDE5i's once metabolic workup complete.

WHEN TO REFER

- 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

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