



Gynae and obstetrics presentations

▼ Common presentations in ED

Gynecological emergencies are common in the emergency department and require prompt attention. Some of the most common gynecological emergencies include pelvic inflammatory disease, ectopic pregnancy, ovarian torsion, and vaginal bleeding. In some cases, PV bleeding may not be a medical emergency and can be managed in UCC/EPAU.

Ectopic pregnancy is a potentially life-threatening condition in which a fertilized egg implants itself outside of the uterus, usually in one of the fallopian tubes. The condition requires immediate medical attention and can cause severe abdominal pain and vaginal bleeding. If left untreated, it can lead to rupture of the fallopian tube and significant blood loss. Ectopic pregnancy is most likely to happen in the first trimester (<12 weeks) but is most commonly discovered at 7-8/40.

Ovarian torsion is a medical emergency that occurs when an ovary twists around its blood supply, cutting off the blood flow to the ovary. This can cause severe pain and, if left untreated, can lead to the death of the ovary. It is most common in women of reproductive age and can occur spontaneously or be associated with an underlying ovarian mass or cyst. Symptoms may include sudden, severe pain in the lower abdomen, nausea, and vomiting.

Menorrhagia is a medical term used to describe heavy menstrual bleeding. It is defined as menstrual bleeding that lasts more than seven days or involves the loss of more than 80 milliliters of blood per cycle. Menorrhagia can be caused by a variety of factors, including hormonal imbalances, uterine fibroids, and certain medications. It can lead to anemia, fatigue, and other health complications if left untreated.

Bartholin's cyst is a relatively common condition in which a cyst forms in one of the Bartholin's glands, located on either side of the vaginal opening. The cyst can cause discomfort, pain, and swelling, and in some cases, it can become infected and lead to an abscess. Treatment options include warm compresses, drainage, and antibiotics. In some cases, surgical removal of the gland may be necessary. These patients are managed by gynae.

Postnatal emergencies present less commonly but it is important to understand the referral process. Some of the most common postnatal emergencies include postpartum hemorrhage, thromboembolic events, and infection. Postpartum hemorrhage is defined as excessive bleeding after childbirth and is one of the leading causes of maternal mortality worldwide. Symptoms may include heavy bleeding, dizziness, and low blood pressure. Thromboembolic events, such as deep vein thrombosis and pulmonary embolism, can occur in the postpartum period and can be life-threatening if not treated promptly. Infection is also a common postnatal complication and can be caused by a variety of factors, including poor hygiene, prolonged labor, and tissue trauma during childbirth. Symptoms may include fever, chills, and abdominal pain.

Gynae services in JR/OUH

1. Gynae triage (JR Women's Centre, open 24/7) - patients can be referred to gynae triage by GP, SCAS or ED. Gynae triage will see patients with gynaecological presentations <16/40. Referrals are made via the Gynae SpR (4630)
2. Maternity Assessment Unit (JR Women's Centre, open 24/7) - patients can self refer to MAU, be referred by GP, 111 or ED. MAU is primarily a midwife-led unit and will see patients with primary obstetrics presentations >16/40. They will also see postnatal patients with infection/bleeding/?DVT/?PE. Referral is via extension 20221/40429
3. EPAU (Rose Hill Community Centre, open Monday to Friday 0800-1800) - patients must self refer to EPAU and cannot present without an appointment. EPAU is appropriate for minor PV bleeding/spotting, mild pain or other non-emergent concerns re early pregnancy. Patients can be given the EPAU

number at streaming to call - **01865 221142** - or can be directed to self refer when unit open

▼ Initial ED Assessment

Taking a history:

- PV bleeding - duration of bleeding, how much bleeding (quantify by number of pads changed in 12/24 hours), clots/tissue visible, colour of blood
- Abdo pain - assess using OLDCARTS, enquire re shoulder tip pain (sensitive test for ectopic pregnancy), any history of ovarian cysts/PCOS
- Pregnancy - date of last period, date of first positive pregnancy test, previous pregnancies (complications, any previous miscarriages), any follow up they have had so far (ultrasounds etc)

Assessment:

- Vital signs - assess for signs of shock (hypotension, tachycardia) and infection (hyperthermia)
- Bloods and access - gain patent IV access (18G preferred in bleeding patients) and send full set of bloods including group and screen - *this is especially important if referring to gynae triage as their nurses are generally not trained to insert cannulas and they have reduced medical presence on the ward*. Ensure you have VBG checked by SHO/Reg in ED and check the Hb yourself to know for referral
- ECG - if tachycardic, gain an ECG for completeness - have signed by ED Reg
- Pain relief - ensure adequate analgesia given in ED
- Antiemetics - ensure antiemetic given ASAP to vomiting patients
- Urine dip and bHCG - gain urine sample ASAP, ensure consent for HCG
- **REMEMBER - if clinical concern about patient (high NEWS score, severe pain, looks unwell) escalate ASAP to senior nurse and senior ED doctor**

▼ You've completed the assessment, what next?

Appropriate patients to refer to gynae directly:

- Confirmed pregnancy <12/40 (positive HCG), moderate-heavy PV bleeding, stable or unstable vital signs, lower abdo pain (localised to left or right) +/- shoulder tip pain
- Moderate-heavy PV bleeding with vital sign instability/dizziness/weakness and Hb drop without pregnancy
- Severe lower abdo pain without pregnancy and history of PCOS/ovarian cysts
- Bartholin's cyst - signs of infection, pain, increasing in size

Appropriate patients to refer to MAU directly:

- Confirmed pregnancy >16/40 (positive HCG) or recently postnatal with bleeding, abdo pain, signs of infection, SOB or ? DVT

Appropriate patients for UCC/EPAU self referral:

- Early pregnancy spotting/minor bleeding with no pain associated
- Early pregnancy cramping/pain with no bleeding associated

▼ You've successfully referred the patient and they've been accepted, now what?

- Discuss with NIC of the area to let them know the patient has been accepted
- The patients will need an 'R' put on EPR and an 'A' for the accepting team - each area will have a piece of paper with the consultants for each speciality on that day
- Handover to the accepting ward - no handover needed for MAU as the midwives take the referrals directly. Gynae triage handover number is 22011
- Is the patient safe for transfer? Any vital sign instability? Ongoing heavy bleeding? If any clinical concerns ensure patient is accompanied on

transfer or kept in ED until stable - if the patient is needing resus request that the team review patient in ED and escalate to ED Reg/Consultant

- If safe for transfer, book porter and inform patient