O&G in the ED

Common presentations and problem solving

PV bleeding

Approach

History is essential to the diagnosis

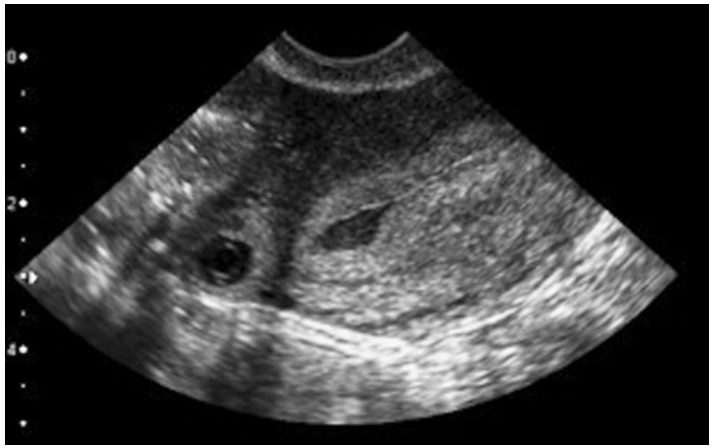
- Age of patient
- Pregnancy status
- Severity of bleeding
- Associated features- pain, syncope, clinical suggestion anaemia
- Timeframe

Differentials

- Menses
- Pregnancy related complications
- Infection
- Trauma
- Dysfunctional uterine bleeding/ anovulation/fibroids
- Malignancy
- Coagulopathy
- Not PVB!!

DO NOT MISS

- Ectopic
  - Will trick you if you're not suspicious
  - "there must be bleeding" "they always have cervical excitation" "she's asymptomatic, can't be!" "ectopics look unwell" "she has no risk factors"
  - Caution with negative urinary bHCG- do a quant if you are suspicious
  - ANY WOMAN WITH A POSITIVE HCG IS ECTOPIC UNTIL PROVEN OTHERWISE
  - Risk factors
    - Mirena
    - Previous ectopics
    - Previous surgery
    - Endometriosis
    - IVF/ovarian hyperstimulation



Age can guide the ddx

- Premenopausal
  - Menarche- period irregular, can be heavy
  - Always do a pregnancy test
  - If they aren't pregnant and have PVB, remember menses can be early/late/change
  - Women with other gynae diagnoses eg. endometriosis/PCOS/fibroids are predisposed to menorrhagia and dysmenorrhea
- Post menopausal
  - Endometrial cancer until proven otherwise
  - USS is a useful modality to assess for fibroids or alternative causes
  - All women should be referred to OP gynae for consideration of hysteroscopy

What does the gynae reg want to know?

- Is she pregnant?
- How heavy is the bleeding?
  - Frequency of pad/tampon changes
  - >1 per hour for > 3 hours = gynae review +/- admission
  - Anaemia, syncope or haemodynamic instability warrants review +/- admission
- How long has she been bleeding?
  - Important for diagnosis and risk stratification
- Any predisposing conditions, medications or surgeries?
  - Contraceptives, IUD
  - Recent TOP or delivery- ?endometritis , secondary PPH
  - Are they already on tranexamic/mefenamic and refractory?
- Is there associated pain?
  - Is this endometriosis? Cervicitis or PID?

Pelvic pain

A complex topic

- Acute
  - Gynae
    - Mittelzmirtz
    - Menses related
    - Endometriosis
    - Fibroids
    - Cyst
    - Torsion
  - Obstetric
    - ectopic
  - Surgical
    - Pelvic appendix
    - Diverticular disease
  - Other
    - UTI
    - Renal calculi
    - MSK
    - psychological
- Chronic
  - VERY DIFFICULT

DO NOT MISS

- Ovarian torsion
  - Difficult diagnosis
  - Think of when
    - Patient is vomiting
    - Pain is disproportionate
    - High opiate requirement
    - Known ovarian cyst >5mm
    - Intercurrent fertility treatment

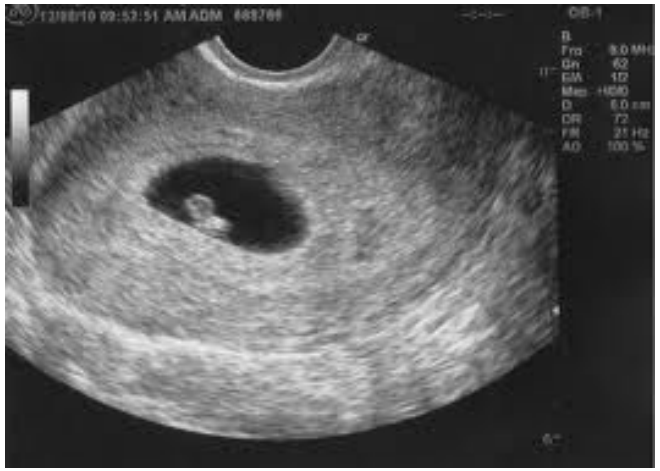
Early Pregnancy <20/40

Common ED presentations

- Bleeding
- Pain
- UTI

Bleeding in early pregnancy

- Initial assessment
  - WHERE IS THE PREGNANCY
  - Amount of bleeding
  - Timing of bleeding
  - Spontaneous or traumatic
  - Assoc sx



- Next steps
  - Physical exam, obs, bedside USS
  - Formal USS
  - HCG- if FHR not seen on USS→ rpt 48 hours later
  - +/- Blood group and hold
  - EPAS
  - Discharge advice

Pain in early pregnancy

- Exclude surgical causes
- Round ligament pain
  - Common in early 2nd trimester
  - Sharp, deep groin/lower abdominal pain
- Cystitis/pyelonephritis
- Constipation
- Chest pain
  - Pregnancy is a hypercoagulable state
  - Investigation depends on degree of suspicion of PE
  - CXR can be performed to exclude alternate causes
  - D-dimer can be useful
  - VQ in early pregnancy, CTPA in late pregnancy

UTI in pregnancy

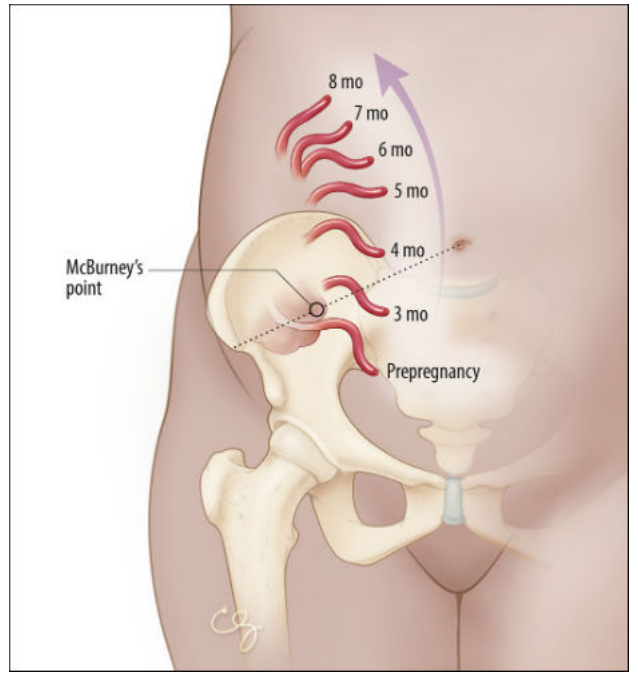
- Treat, even if asymptomatic
  - Asymptomatic bacteriuria in pregnancy has a 30% increased risk of developing pyelonephritis in later pregnancy
- ETG has a good guideline
  - Empiric therapy
    - Nitrofurantoin 100mg QID for 5 days OR
    - Keflex 500mg BD for 5 days OR
    - Trimethoprim 300mg daily for 3 days (2nd and 3rd trimester only)
- Pyelo should always be admitted to SSOU vs gen med for close observation
  - Higher risk of adverse maternal and foetal outcomes
  - Empiric therapy
    - Gentamicin AND
    - Ampicillin 2g QID

Late Pregnancy >20/40

Common ED presentations

- Bleeding
  - If pregnancy is viable (ie >26 weeks) will usually go straight upstairs for assessment
  - If < 26 weeks, asx is similar to bleeding in early pregnancy- always call O&G for advice
- Decreased foetal movements
  - As above
  - Note foetal movements are not usually appreciable until 20 weeks, 22-24/40 if anterior placenta
- Other medical problems
  - High risk of respiratory deterioration- high morbidity with LRTI, influenza
  - UTI/pyelo
  - Pelvic pain- often ligamentous
  - Cholestasis
    - ITCH +/- jaundice
    - Mx is ursodeoxycholic acid and often delivery is expedited

DO NOT MISS



- Appendicitis in pregnancy
  - Tricky!
- Pre-eclampsia
  - SBP >140 or DBP >90 after 20/40
  - Dipstick for PU
  - Check FBE, UEC, LFT, coags, FBE looking for complications (eclampsia, HELLP
  - Neuro asx
  - Call O&G and prepare for deterioration