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SMF PCP Treatment & Referral Guidelines
Gynecology

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I. **Bleeding disorders in women – a Primary Care Approach**

A. Definitions:

1. Menorrhagia – Menstrual blood loss greater than 80ml/cycle or lasting longer than seven days
2. Intermenstrual bleeding – Bleeding or spotting between normal periods
3. Metrorrhagia – light bleeding from the uterus at irregular intervals
4. Menometrorrhagia - heavy bleeding from the uterus at irregular intervals
5. Polymenorrhea – Menstrual interval less than 24 days
6. Oligomenorrhea – Menstrual interval greater than 35 days
    a) Comment: Make sure you define the pattern with a written menstrual calendar
7. Anovulatory bleeding: unpredictable endometrial bleeding of variable flow and duration
    a) Due to chronic estrogen production unopposed by adequate progesterone leading to thickened endometrium with partial and irregular shedding.
8. Dysfunctional
    a) Bleeding in the absence of pathology – Usually Anovulatory
    b) No tumor
    c) No infection
    d) No pregnancy
    e) 75% in adolescent women
9. Post coital bleeding – Vaginal bleeding which is noted within 24 hours of intercourse

B. Workup Initially:

1. HCG – if of reproductive age and sexually active
2. CBC
3. TSH
4. FSH – if patient has oligomenorhea over 40 years old or premature menopause suspected
5. Endometrial biopsy – peri-menopause age > 35
6. Consider coagulation studies if menorrhagia at menarche or associated with other signs of bleeding diathesis.
7. Ensure patient is up to date with cervical cancer screening
8. Postmenopausal uterine bleeding should be evaluated with either transvaginal US to evaluate endometrial stripe or endometrial biopsy. If persistent bleeding despite normal TVUS (<= 4mm) or benign endometrial biopsy then refer.

C. Potential Primary Care Therapies

1. Menorrhagia-
    a) Fibroids suspected or shown on ultrasound → Refer

b) No pathology, no polyps, no fibroids →Trial of NSAID's or OCP's refer if not improved.

2. Irregular Bleeding (short cycles or skips)
   a) No treatment if not repetitive.
   b) Menstrual calendar to confirm pattern.
   c) Trial of OCP's unless patient desires pregnancy.
   d) Endometrial biopsy if bleeding prolonged > 7-10 days and cycles are very irregular
3. Physiologic intermenstrual bleeding at the time of expected ovulation is secondary to the brief abrupt decline in estradiol that follows its preovulatory surge. If at irregular times then order ultrasound to look for uterine pathology and refer.

II. Pelvic Pain

A. Acute Pain

1. Most Common
   a) Dysmenorrhea
   b) Ectopic Pregnancy
   c) Pelvic Inflammatory disease / Tubo ovarian abscess
   d) Hemorrhage, rupture, or torsion of ovarian neoplasm or cyst
   e) Endometriosis , especially rupture of endometrioma
   f) Endometritis
   g) Other cause – non-GYN
      (1) Appendicitis,
      (2) Acute Cystitis
      (3) Diverticulitis
      (4) Urinary tract calculi
2. Diagnosis
   a) Bimanual pelvic exam
   b) Relation to menses
   c) Consider irritable bowel syndrome (IBS) – left-sided pain, can be related to mild cycle pain that may be related to ovulation
   d) Psychological causes – chronic pain, childhood sexual abuse

B. Chronic Pain

1. Differential diagnosis
2. GYN
   a) Endometriosis
   b) Ovarian Cancer
   c) Dysmenorrhea
   d) Adnexal mass
   e) Chronic Pelvic Inflammatory disease
3. Non-GYN
   a) Bowel diseases
   b) Psychological
   c) Urologic – Interstitial cystitis

   d) Neurologic
4. Evaluation
   a) Bimanual pelvic exam
   b) CBC
   c) Urinalysis
   d) Testing for Chlamydia or gonorrheal infection
   e) Pregnancy test
   f) If above labs negative then order pelvic ultrasound and refer to gynecology

APPROVAL:

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SMF Medical Director

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