Monash Health Referral Guidelines
(incorporating Statewide Referral Criteria)
GYNAECOLOGY

CONDITIONS

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Monash Pregnancy Choices (MPC)

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PAEDIATRIC & ADOLESCENT GYNAE
Paediatric and Adolescent Gynaecology

ENDOMETRIOSIS
Endometriosis

Last updated:
October 2025

Monash Health Referral Guidelines
(incorporating Statewide Referral Criteria)
GYNAECOLOGY

PRIORITY

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

EMERGENCY	For emergency cases please do any of the following: - send the patient to the Emergency department OR - Contact the on call registrar OR - Phone 000 to arrange immediate transfer to ED
URGENT	The patient has a condition that has the potential to deteriorate quickly with significant consequences for health and quality of life if not managed promptly.
ROUTINE	The patient's condition is unlikely to deteriorate quickly or have significant consequences for the person's health and quality of life if the specialist assessment is delayed beyond one month

REFERRAL

How to refer to Monash Health

Secure eReferral by HealthLink is now our preferred method of referral.

Find up-to-date information about how to send a referral to Monash Health on the eReferrals page on our website

CONTACT US

Medical practitioners

To discuss complex & urgent referrals contact the on call registrar at Monash Medical Centre on 9594 6666:

1. Gynae-oncology registrar or
2. Gynaecology registrar

For Termination of pregnancy contact 9594 2457

General enquiries

Phone: 1300 342 273

CONTRACEPTIVE COUNSELLING

CONTRACEPTION

WHEN TO REFER?

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Missing or lost strings on an intra-uterine device
- Request for tubal ligation
- Where hormonal contraception is contraindicated
- Where contraception is unable to be managed in primary care due to a complex medical condition (e.g. immunosuppression, breast cancer, multiple sclerosis, physical disability).

Information to be included in the referral

Information that **must** be provided

- Past gynaecological history including menstrual health and details of previous experience with contraception
- Relevant family history

Provide if available

- Current cervical screening results
- Sexually transmitted infections test results
- Most recent human papillomavirus (HPV) and liquid-based cytology (LBC) co-test result or cervical screening test results

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Referrals should be made to suitable community-based services wherever possible (see 1800 My Options).

Where a public health service also operates a community health service or GP clinic, demand for reproductive health services should be met through these GP clinics.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Note the statement on reversal of sterilisation in Victoria's *Elective Surgery Access Policy 2015*

Referral to a public hospital is not appropriate for

Reversal of tubal ligation requests go to the Reproductive Medicine Unit **(applies to Monash Health only).**

Routine

For procedure or insertion of device

Additional Resources

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Contraception and sterilisation

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

PREGNANCY CHOICES

PREGNANCY CHOICES

WHEN TO REFER?

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Surgical termination of pregnancy at later gestations
- Surgical termination of pregnancy where medical termination is no longer appropriate and services cannot be accessed outside of a public health service

Information to be included in the referral

Information that **must** be provided

- Results of human chorionic gonadotropin (hCG) confirming pregnancy
- Results of pelvic ultrasound confirming pregnancy and weeks of gestation
- Documented Rhesus blood group

Provide if available

- Results of STI screening tests including Chlamydia, gonorrhoea, HIV, syphilis and hepatitis B and C
- Results of most recent cervical screening test

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Medical termination of pregnancy managed in primary care is preferred to surgical terminations where practicable.

Referrals should be made to suitable community-based services wherever possible (see 1800 My Options). A referral to a health service may be necessary if there is no suitable local community-based service available.

Providing surgical termination of pregnancy of later gestation requires specialist surgical staff and support services. Women who require this service should be directed to designated service providers.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

Urgent

Please contact Contraceptive Clinic on 9594 2455 Monday to Friday between 9am and 5pm.

Additional Resources

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Termination of pregnancy

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

DYSPLASIA

DYSPLASIA/ ABNORMAL CERVICAL SCREENING TEST

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Positive human papillomavirus, types 16 or 18, detected
- Positive human papillomavirus detected (but not types 16 or 18) and either;
    - possible or confirmed high-grade squamous intraepithelial lesions or any glandular abnormality
    - gynaecology assessment recommended by cytology service
- Human papillomavirus, (not 16/18) with negative or possible or confirmed low-grade squamous inintraepithelial lesion with either:
    - persistent across two tests (index test with a 12-months repeat) if the patient has any of the following:
    - identifies as Aboriginal and/ or Torres Strait Islander
    - is 50 years or older
    - persistent across three tests (index test, 12-months repeat, and 24-months repeat)
- People aged between 70 and 74 years of age, a history of immunosuppression or diethylstilbesterol (DES) exposure and human papillomavirus (any type) detected
- Colposcopy assessment recommended by cytology service.

Information to be included in the referral

Information that **must** be provided

- Most recent human papillomavirus (HPV) and liquid-based cytology (LBC) co-test result or cervical screening test results
- History of any abnormal bleeding or abnormal change
- If the woman has an immune-deficiency or is immunosuppressed
- If the woman is pregnant.

Provide if available

- If the person identifies as an Aboriginal and /or Torres Strait Islander.
- History of exposure to diethylstilbesterol (DES)

Continued over page

WHEN TO REFER?

Emergency

Immediately contact the gynaecology registrar to arrange an urgent gynaecological assessment for:

- Visible suspicious cervical mass

In cases of frank malignancy ring the Gynae-Oncology Unit on 9594 6666

Additional Resources

SEMPHN Pathways
Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Cervical Screening

HealthPathways
Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

DYSPLASIA

DYSPLASIA/ ABNORMAL CERVICAL SCREENING TEST (Continued)

Additional comments

Cervical screening test results may be provided from either self-collected or clinician collected samples.

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Referral to a public hospital is not appropriate for

In line with the cervical screening pathway:

- Human papillomavirus is not detected
- There are unsatisfactory liquid-based cytology or human papillomavirus testing
- Possible, or confirmed, low-grade squamous intraepithelial lesions where human papillomavirus is not detected.

Initial GP Work Up

- An up to date cervical screening test (CST)
- STI screen and vaginal/cervical swabs where appropriate
- History of previous abnormal results
- Sexual history/recent change of partner
- HPV vaccination history
- History of IMB,PCB,PMB or watery discharge

Management Options for GP

- Repeat CST as per Guidelines for the Management of Asymptomatic women with screen detected abnormalities
- Consider using Oestrogen cream in post-menopausal patients
- Ultrasound in cases of PMB, IMB
- Pap smear in all cases of PMB
- Exclude and treat STI’s

BACK

DYSPLASIA

VULVAL ULCERS

WHEN TO REFER?

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 STI screen
- Bloods for serology as appropriate i.e. 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

BACK

VULVAL DISORDERS

WHEN TO REFER?

Initial GP Work Up

- History of complaint
- Associated factors i.e. Candida
- Age of patient
- Symptoms of discharge or systemic illness, chronic disease
- Presence of extensive leukoplakia

Management Options for GP

- Swabs
- General blood tests i.e. FBE
- Use of mild topical cortisone cream for a short period may be appropriate
- Treat candida-vaginally and topically
- Avoid soap and shower gels

BACK

DYSPLASIA

GENITAL WARTS

WHEN TO REFER?

Initial GP Work Up

- History of appearance
- Sexual; history, change of partner
- CST history
- History of smoking/immunosuppression

Management Options for GP

- CST
- STI screen
- Counselling
- Use of topical agents such as Aldara or Podophyllinrat

BACK

GYNAECOLOGY ENDOSCOPY

OVARIAN AND OTHER ADNEXAL PATHOLOGY

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Suspected malignancy identified on clinical examination or imaging
- Pre-menopausal complex ovarian cyst, suspected endometrioma, or dermoid
- Persistent and enlarging ovarian cyst confirmed with imaging performed at least three months apart
- Symptomatic hydrosalpinx.

Information to be included in the referral

Information that **must** be provided

- Past medical history including pain and other symptoms
- Family history of breast and ovarian cancer
- Imaging results
- Cancer antigen 125 (CA 125) results if the woman is being referred for suspected malignancy or post-menopausal ovarian cyst.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Initial GP Work Up – Ovarian Cysts

Detailed History including:

- Is presentation Asymptomatic or Symptomatic?
- Incidental clinical or ultrasound finding
- 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+/-

Continued over page

WHEN TO REFER?

Emergency

Direct to an emergency department that can provide a gynaecology assessment:

- Acute, severe pelvic or abdominal pain
- Ectopic pregnancy
- Suspected torsion of ovary
- Suspected pelvic sepsis
- If the woman is haemodynamically unstable

Urgent

- Suspected malignancy
- Symptomatic hydrosalpinx

Additional Resources

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Ovarian cyst pathway

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

GYNAECOLOGY ENDOSCOPY

OVARIAN AND OTHER ADNEXAL PATHOLOGY (Continued)

Initial GP Work Up – Ovarian Cysts (cont.)

Investigations:

- Examination
  - Size
  - Consistency
  - Contour
- Ultrasound scan (performed by a specialist experienced in Gynaecological Ultrasound)
- Tumour Markers (CA 125, Ca 19.3, AFP, CEA, hCG, LDH, Inhibin) ROMA test

Management Options for GP – Ovarian Cysts

- 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.

BACK

GYNAECOLOGY ENDOSCOPY

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?

Routine

Asymptomatic: Refer as soon as possible

BACK

GYNAECOLOGY ENDOSCOPY

ACUTE PELVIC INFLAMMATORY DISEASE

WHEN TO REFER?

Initial GP Work Up

- Symptomatology including:
  - Pain
  - Discharge
  - Pyrexia
- Out of phase bleeding
- ? presence of IUCD

Investigations

- FBE/ESR
- HVS/Chlamydia smear/swabs
- Urine specimen -Chlamydia
- Endocx/urethra l/rectal swab
- HCG
- ?Smear

Management Options for GP

- Antibiotics for Pelvic Inflammatory Disease.
- Triple therapy:
  - Augmentin 500mgs TDS 10 days
  - Flagyl 400mgs TDS 7 days
  - Doxycycline 100mgs BID minimum 14 days

  (Note: Erythromycin may be used as an alternative to Augmentin in cases of penicillin allergy)
- Link and liaise with STI clinic as appropriate

Urgent

- Positive pregnancy test with pelvic pain +/- fever (consider abortion). Refer for admission
- Acutely unwell, pelvic mass, unresponsive to treatment (12-16 hours)

BACK

CHRONIC PELVIC INFLAMMATORY DISEASE

WHEN TO REFER?

Initial GP Work Up

- Symptomatology including:
  - Chronic pain
  - Discharge
  - Erratic bleeding
  - Recurrent episodes of acute PIO
  - Dyspareunia

Investigations

- Refer to Acute Pelvic Inflammatory Disease
- Ultrasound scan

Management Options for GP

Symptomatic after treatment - refer

Routine

Chronic PIO: Unresponsive to treatment

BACK

GYNAECOLOGY ENDOSCOPY

PERSISTENT PELVIC PAIN

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Persistent pelvic pain that has not responded to adequate medical management.

Information to be included in the referral

Information that **must** be provided

- Past medical history including:
- Obstetric and gynaecological history
- Pain severity, duration, any link to menstrual cycle or dysmenorrhea
- How pain is different to any co-existing gastrointestinal pain
- Any previous pelvic inflammatory disease
- Any history of sexual abuse
- Previous medical and surgical management
- Current and complete medication history (including non-prescription medicines, herbs and supplements)
- Any medicines previously tried, duration of trial and effect.

Provide if available

- Most recent human papillomavirus (HPV) and liquid-based cytology (LBC) co-test result or
- Current cervical screening results
- Sexually transmitted infections test results.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Specialist multidisciplinary programs for women experiencing complications with transvaginal mesh are available at:

- Royal Women's Hospital
- Mercy Hospital for Women
- Monash Health
- Western Health.

Women may also be referred to a chronic pain service. Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

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?

Emergency

Direct to an emergency department that can provide a gynaecology assessment:

- Acute, severe pelvic or abdominal pain

Routine

If diagnosis is uncertain

Additional Resources

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Persistent pelvic pain

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

GYNAECOLOGY ONCOLOGY

CANCER OF THE CERVIX

WHEN TO REFER?

Initial GP Work Up
- FBE, UEC if bleeding
- CST

Urgent
Contact the Gynae-Oncology Unit

Management Options for GP
Refer to gynaecology

BACK

OVARIAN CANCER

WHEN TO REFER?

Initial GP Work Up
- CA125, CA19.9, CEA
- Other tumor markers as per gynaeoncology team. ROMA test
- Pelvic USS+/- CT (C/A/P)
- FBE, UEC

Urgent
Contact the Gynae-Oncology Unit

Management Options for GP
Refer to gynaecology

BACK

GYNAE CANCERS -SUSPECTED AND CONFIRMED

WHEN TO REFER?

Initial GP Work Up
- FBE, UEC
- Pelvic USS+/- CT
- CST

Urgent
Contact the Gynae-Oncology Unit

Management Options for GP
Refer to gynaecology

BACK

MENOPAUSE

URNER'S SYNDROME

WHEN TO REFER?

Initial GP Work Up

Previous information re history and diagnosis of Turner's Syndrome, ongoing management details including hormone therapy and results

Routine

When is in transition from paediatric to adult long term follow up. New hormone therapy issues.

Management Options for GP

- Refer to Adult Turner's Syndrome Long term Care Clinic.

Turners Clinic operates on the first Thursday in March, June, September and December

BACK

MENOPAUSE AFTER CANCER, MENOPAUSE AFTER RISK REDUCTION SURGERY

WHEN TO REFER?

Initial GP Work Up

Information of diagnosis, management and therapy of cancer

Routine

With onset of symptoms of menopause or prior to risk reduction surgery

Management Options for GP

Refer to Menopause after cancer clinic

BACK

PREMATURE MENOPAUSE, SURGICAL MENOPAUSE

WHEN TO REFER?

Initial GP Work Up

Two FSH/E2 levels at least 1 month apart if spontaneous menopause

Routine

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

Management Options for GP

Refer Early Menopause Clinic

BACK

MENOPAUSAL PROBLEMS WITH COMPLEX MEDICAL OR SURGERY PROBLEMS OR GENERAL MENOPAUSE

WHEN TO REFER?

Initial GP Work Up

Information about medical or surgical history

Routine

Refer to Menopause Clinic

Management Options for GP

N/A

BACK

MENSTRUAL MANAGEMENT

PERSISTENT, HEAVY MENSTRUAL BLEEDING

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Persistent, heavy menstrual bleeding that has not responded to adequate trial of medical treatment.

Information to be included in the referral

Information that **must** be provided

- Findings from physical examination
- Past medical history (e.g. diabetes, polycystic ovary syndrome)
- Transvaginal pelvic ultrasound results. (Transabdominal pelvic ultrasound results can be provided for women who have not become sexually active, are a survivor of sexual assault or have declined a transvaginal pelvic ultrasound.)
- Full blood count
- Iron studies.

Provide if available

- Most recent human papillomavirus (HPV) and liquid-based cytology (LBC) co-test result or cervical screening test results
- Thyroid stimulating hormone (TSH)

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Referrals should be made to suitable community-based services wherever possible (see 1800 My Options).

Where a public health service also operates a community health service or GP clinic, demand for reproductive health services should be met through these GP clinics.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

WHEN TO REFER?

Emergency

Direct to an emergency department that can provide a gynaecology assessment:

- Uncontrolled vaginal bleeding, or if the woman is haemodynamically unstable

Urgent

Anaemia Hb < 80 g/l

Additional Resources

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Heavy menstrual bleeding

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

MENSTRUAL MANAGEMENT

PERSISTENT, HEAVY MENSTRUAL BLEEDING (Continued)

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

Investigations

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

Management Options for GP

- Hormonal control, e.g. oral contraceptive /HRT
- Non steroidals, e.g. 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, e.g. hypo / hyper thyroidism

BACK

MENSTRUAL MANAGEMENT

BARTHOLIN'S CYSTS / VAGINAL LESIONS

WHEN TO REFER?

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

Routine

For cyst management

BACK

MENSTRUAL MANAGEMENT

POST-MENOPAUSAL BLEEDING

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Post-menopausal bleeding with a thickened endometrium (>4mm measured on transvaginal pelvic ultrasound)
- Post-menopausal bleeding with polyp confirmed by imaging
- Post-menopausal bleeding in a woman taking tamoxifen.
- Persistent or unexplained bleeding

Information to be included in the referral

Information that **must** be provided

- Findings from physical examination
- Most recent cervical screening results
- Transvaginal pelvic ultrasound results. (Transabdominal pelvic ultrasound results can be provided for women who have not become sexually active, are a survivor of sexual assault or have declined a transvaginal pelvic ultrasound.)
- Past medical history (e.g. diabetes, polycystic ovary syndrome)
- Sexually transmitted infections test results.

Provide if available

- Recent human papillomavirus (HPV) and liquid-based cytology (LBC) co-test result
- Weight
- Body mass index.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Referral to a public hospital is not appropriate for

Single episode of bleeding with an endometrium (<4mm measured on transvaginal pelvic ultrasound), with negative cervical screening results.

Continued over page

WHEN TO REFER?

Emergency

Direct to an emergency department that can provide a gynaecology assessment:

- Uncontrolled vaginal bleeding, or if the woman is haemodynamically unstable

Urgent

If endometrial thickness >10mm on ultrasound

Additional Resources

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Postmenopausal bleeding

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

MENSTRUAL MANAGEMENT

POST-MENOPAUSAL BLEEDING (Continued)

Initial GP Work Up

- Drug history (contraception, HRT particularly oestrogen only regimens)
- Evidence of any genital tract abnormalities, e.g. cervical polyps / atrophic change or abdominal mass
- Sexual/ PIO history

Investigations

- CST
- HVS
- 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

BACK

MENSTRUAL MANAGEMENT

POST-COITAL BLEEDING

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Unexplained post-coital bleeding.

Information to be included in the referral

Information that **must** be provided

- Findings from physical examination
- Transvaginal pelvic ultrasound results. (Transabdominal pelvic ultrasound results can be provided for women who are a survivor of sexual assault or have declined a transvaginal pelvic ultrasound.)
- Past medical history (e.g. diabetes, polycystic ovary syndrome)
- Most recent cervical screening test results
- Sexually transmitted infections test results.

Provide if available

- Recent human papillomavirus (HPV) and liquid-based cytology (LBC) co-test result

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

Initial GP Work Up

- Examine
- CST
- HVS

Management Options for GP

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

WHEN TO REFER?

Emergency

Direct to an emergency department that can provide a gynaecology assessment:

- Uncontrolled vaginal bleeding, or if the woman is haemodynamically unstable

Additional Resources

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Postcoital bleeding

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

MENSTRUAL MANAGEMENT

PERSISTENT OR UNEXPLAINED INTERMENSTRUAL BLEEDING

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Persistent or unexplained intermenstrual bleeding.

Information to be included in the referral

Information that **must** be provided

- Most recent cervical screening results
- Transvaginal pelvic ultrasound results. (Transabdominal pelvic ultrasound results can be provided for women who have not become sexually active, are a survivor of sexual assault or have declined a transvaginal pelvic ultrasound.)

Provide if available

- Findings from physical examination
- Recent human papillomavirus (HPV) and liquid-based cytology (LBC) co-test result
- Past medical history (e.g. diabetes, polycystic ovary syndrome)
- Sexually transmitted infections test results.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service

WHEN TO REFER?

Emergency

Direct to an emergency department that can provide a gynaecology assessment:

- Uncontrolled vaginal bleeding, or if the woman is haemodynamically unstable

Additional Resources

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Intermenstrual bleeding

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK

MENSTRUAL MANAGEMENT

FIBROIDS

Initial GP Work Up

- Ultrasound

Management Options for GP

- Nil

WHEN TO REFER?

Routine

Asymptomatic: Refer as soon as possible

BACK

PELVIC FLOOR / UROGYNAECOLOGY

PELVIC ORGAN PROLAPSE (POP)

WHEN TO REFER?

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

Investigations

- MSU

Consider

- FBE
- Biochemistry
- Enal 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)

Routine
Symptomatic prolapse

Note: For patients with mild-moderate POP symptoms, an appointment will be an Advanced Practice Physiotherapist for initial assessment and onward management (which may include consultation with/referral to medical team)

BACK

URINARY INCONTINENCE / VOIDING DIFFICULTY

WHEN TO REFER?

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

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)

BACK

RECURRENT UTIS

WHEN TO REFER?

Initial GP Work Up

- MSU
- Renal and bladder US

Management Options for GP

- Vaginal estrogen
- Cranberry
- Hiprex and vit C
- Postcoital or low dose antibiotics

Routine

- Symptomatic or bothersome urinary or anal incontinence;
- Symptomatic or bothersome urinary frequency, nocturia
- Symptomatic or bothersome voiding difficulty, bladder pain,
- Recurrent Utis; haematuria

BACK

REPRODUCTIVE MEDICINE

INFERTILITY

WHEN TO REFER?

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

Routine

- If >12 months infertility and < 38 years of age
- If >6 months infertility and >38 years of age

Management Options for GP

Specific treatments depend on specific problems identified as noted below (primary amenorrhoea, secondary amenorrhoea)

BACK

PRIMARY AMENORRHOEA

WHEN TO REFER?

Initial GP Work Up

- Age > 15
- Weight history
- Dietary and 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

Routine

Primary amenorrhoea – where there are abnormal results or significant patient stress / anxiety

Management Options for GP

Counselling and support

BACK

SECONDARY AMENORRHOEA (> 6 MONTHS)

WHEN TO REFER?

Initial GP Work Up

- As for primary amenorrhoea
- Contraception history
- Drug history, e.g. psychtrophic
- 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)

Routine

Secondary amenorrhoea – where there are abnormal results or significant patient stress / anxiety

Management Options for GP

Counselling and support

BACK

REPRODUCTIVE MEDICINE

MALE INFERTILITY

WHEN TO REFER?

Initial GP Work Up

•Semen analysis (preferably at specialist lab such as Monash IVF)

Routine
After 6 months of infertility

Management Options for GP

Lifestyle modification, in particular weight management, smoking and alcohol use

BACK

RECURRENT MISCARRIAGES

WHEN TO REFER?

Initial GP Work Up

Careful general and obstetric history

Routine
Generally, following 3rd miscarriage. After 2 miscarriages if maternal age > 38 or if additional history of infertility

Management Options for GP

Lifestyle modification, in particular weight management and smoking cessation.

BACK

TUBAL & VASECTOMY REVERSAL

WHEN TO REFER?

Initial GP Work Up

- Basic fertility check of other partner
- For tubal reversal
  - Semen analysis
- For vasectomy reversal:
  - Ovarian reserve: D2-5 AMH
  - Confirmation of ovulation: D21progesterone

Routine
Refer as appropriate

Management Options for GP

N/A

BACK

ENDOCRINE PROBLEMS (POLYCYSTIC OVARIAN SYNDROME)

WHEN TO REFER?

Initial GP Work Up

- TVUS
- OGTT
- FSH, LH, Prolactin, TSH
- Testosterone, SHBG, Free androgen index

Routine
Refer to Menopause Clinic

Management Options for GP

- Lifestyle changes, in particular weight management
- OCP if not desiring pregnancy

BACK

SEXUAL MEDICINE AND THERAPY CLINIC

SEXUAL & RELATIONSHIP COUNSELLING

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) PIO 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 PDE51's once metabolic workup complete.

WHEN TO REFER?

Routine

- 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

BACK

PAEDIATRIC & ADOLESCENT GYNAECOLOGY CLINIC

PAEDIATRIC AND ADOLESCENT GYNAECOLOGY → WHEN TO REFER?

Patient Presentation

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

Management Options for GP

N/A

Routine

- 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)

BACK

ENDOMETRIOSIS

ENDOMETRIOSIS

DHHS Statewide referral criteria apply for this condition

Criteria for referral to public hospital specialist clinic services

- Suspected endometriosis that has not responded to adequate medical management
- Significant deep dyspareunia
- Dyschezia
- Known endometriosis with associated reproductive issues
- Suspected endometrioma.

Information to be included in the referral

Information that **must** be provided

- Details of previous surgical and medical management including the course of treatment, and outcome of treatment, over the past 12 months
- Transvaginal pelvic ultrasound results. (Transabdominal pelvic ultrasound results can be provided for women who have not become sexually active, are a survivor of sexual assault or have declined a transvaginal pelvic ultrasound.)
- Functional impact of symptoms on daily activities including impact on work, study, school or carer role
- Planning for pregnancy.

Provide if available

- Description of symptoms
- dysmenorrhoea
- deep dyspareunia
- dyschezia
- history of sub-fertility
- sexually transmitted infections test results.

Additional comments

The Summary and referral information lists the information that should be included in a referral request.

Referrals may be made to suitable community-based services wherever possible (see 1800 My Options).

Where a public health service also operates a community health service or GP clinic, demand for reproductive health services should be met through these GP clinics.

Where appropriate and available the referral may be directed to an alternative specialist clinic or service.

Continued over page

WHEN TO REFER?

Emergency

Direct to an emergency department for:

- Severe, uncontrolled pelvic pain
- Known endometriosis with:
  - Hydronephrosis or
  - Bowel obstruction

BACK

ENDOMETRIOSIS (Cont'd)

ENDOMETRIOSIS (Continued)

WHEN TO REFER?

Referral to a public hospital is not appropriate for

Not applicable.

SEMPHN Pathways

Please consult SEMPHN Pathways for assessment, management and referral guidance for this condition:

Endometriosis

HealthPathways

Please refer to HealthPathways Melbourne for guidance in assessing, managing and referring for patient conditions (login required).

BACK