Clinical Prioritisation Criteria

Gynaecology CPC v1.05

Summary

This document contains the draft Clinical Prioritisation Criteria (CPC) for Gynaecology. It is a consultation document only. This is a drafting document and should be read in conjunction with the consultation overview.

The final format will be as indicated on the CPC website https://cpc.health.qld.gov.au/ and embedded into your local HealthPathways site or HHS site i.e. 'Refer your patient' website https://metrosouth.health.qld.gov.au/referrals or www.health.qld.gov.au/metronorth/refer.

For more information about the CPC development process and purpose, please see the accompanying CPC Consultation Overview.

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Gynaecology inclusion for outpatient services

The following conditions are proposed to be considered under the Gynaecology CPC.

Please note this is not an exhaustive list of all conditions for outpatient services and does not exclude consideration for referral unless specifically stipulated in the CPC exclusions section.

- Abnormal pap smear/ cervical dysplasia
- Heavy menstrual bleeding (HMB)
- Post-menopausal bleeding (vaginal bleeding more than 12 months following last menstrual period)
- Ovarian cyst/ pelvic mass
- Post-coital bleeding
- Cervical polyp
- Intermenstrual bleeding
- Primary/secondary amenorrhoea
- Pelvic pain/dysmenorrhea/PMS
- Pelvic floor dysfunction (e.g. prolapse and/or incontinence)
- Fibroids
- Known or suspected endometriosis
- Infertility/RPL/PCOS
- Vulva lesion/ lump/genital warts/ boil/ swelling/ abscess/ ulcer/ Bartholin's cyst
- Dyspareunia (deep or superficial)
- Mirena®/progesterone releasing IUD insertion or removal, for HMB or HRT

Gynaecology exclusions for outpatient services

Not all services are appropriate to be seen in the Queensland public health system. Exceptions can always be made where clinically indicated. It is proposed that the following are not routinely provided in a public Gynaecology service

The following are not routinely provided in a public Gynaecology service:

- Elective cosmetic surgery e.g. labiaplasty

  NB labial hypertrophy in paediatric and adolescent patients: refer to Statewide Paediatric and Adolescent Gynaecology Services (SPAG) at LCCH/RBWH.
- Elective tubal ligation but will be accepted as a category 3, if:
  - patient cannot use/trialled other contraceptive methods
  - patient does not want to pass on any genetic disorders or disabilities
  - indicated for women suffering from medical or obstetric conditions that would contraindicate future pregnancy
  - unless within the scope of the local health service
- Contraception e.g. Implanon
- Routine Mirena®/progesterone-releasing IUD insertion for contraception
  - Unless within the scope of the local health service
- Primary menopausal care
- Cervical screening test
- Postnatal check-up

  NB where available recommend referral to True – relationships and reproductive health (formerly known as Family Planning Queensland) or Women's Health speciality primary care provider/service
- Elective termination of pregnancy
- IVF services
- Reversal of tubal ligation

Referral and outpatient criteria

Abnormal cervical screening / cervical dysplasia/ abnormal cervix

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

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Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Invasive cancer (SCC, glandular, other). For optimum care, patient should be seen by gynaecological oncology within 2 weeks. • LBC of PHSIL/HSIL • AIS or possible high grade glandular lesion • Positive HPV 16/18 and – unsatisfactory LBC – past history of PHSIL/HSIL – past history of positive HPV 16/18
Category 2 (appointment within 90 calendar days)	• Positive HPV 16/18 and – normal LBC – PLSIL/LSIL – Atypical glandular cells/endocervical cells of undetermined significance • Positive HPV non- 16/18 and – Atypical glandular cells/endocervical cells of undetermined significance – previous test positive for oncogenic HPV – women aged 70-74 – immune deficiency • History of diethylstilboestrol (DES) exposure regardless of HPV status or LBC test • Abnormal appearing cervix with normal cervical screening • Post-coital bleeding with normal cervical screening
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

1. Reason for request, indicate on the referral

- To establish a diagnosis
- For treatment or intervention not otherwise accessible to the patient
- For advice regarding management
- To engage in an ongoing shared care approach between primary and secondary care
- Reassurance for GP/second opinion
- Reassurance for the patient/family
- For other reason (e.g. rapidly accelerating disease progression)

2. Essential referral information, Referral will be returned without this

- History of
  - any abnormal bleeding (i.e. post-coital and intermenstrual) or abnormal discharge
  - previous abnormal cervical screening
  - immunosuppressive therapy
- Medical management to date

- Current cervical screening results (LBC should be performed on any sample with positive oncogenic HPV)

3. Additional referral information, Useful for processing the referral

- HPV vaccination history
- STI screen result - endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA
- History of smoking

4. Request

General referral information/Standard information (Appendix 2, Consultation overview)

Notes

- Please note that where appropriate and where available, the referral may be streamed to an associated public allied health and/or nursing service. Access to some specific services may include initial assessment and management by associated public allied health and/or nursing, which may either facilitate or negate the need to see the public medical specialist.
- A change in patient circumstance (such as condition deteriorating or becoming pregnant) may affect the urgency categorisation and should be communicated as soon as possible.
- Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

5. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways and or local guidelines
- Women who are in follow-up for pLSIL/LSIL cytology in the previous program (pre-renewal NCSP) should have a HPV test at their next scheduled follow-up appointment.
  - If oncogenic HPV is not detected, the women can return to 5-yearly screening
- A single Cervical Screening Test may be considered for women between the ages of 20 and 24 years who experienced their first sexual activity at a young age (e.g., before 14 years), who had not received the HPV vaccine before sexual activity commenced.
- Adolescent patients with abnormal HPV should follow the same pathway as adult patients. Patients <25 years old should also have screening for STI as they are a high-risk group.
  Consider using oestrogen cream +/- liquid cytology in post-menopausal patients
- Patients with positive non-16/18 but normal or LSIL on LBC would not need referral and only a repeat CST in 12 months.
- Recall women in 6-12 weeks if they have an unsatisfactory screening report
- Specific efforts should be made to provide screening for Aboriginal and Torres Strait Islander women. They should be invited and encouraged to participate in the NCSP and have a 5-yearly HPV test, as recommended for all Australian women.
- Routine colposcopic examination is NOT routinely required following treatment for CIN II / III. These patients would need a speculum inspection of the cervix and a co-test (i.e. HPV and LBC at 12 months post-treatment. They do not routinely need referral to specialist.

Clinical resources (links)	Patient resources (links)

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

- Ensure they are aware of the request and the reason for being assessed.
- Instruct them to take all relevant radiology films and reports (including the imaging report) to appointments.
- To inform of any change in circumstance (e.g., getting worse or becoming pregnant) as this may affect the request for assessment.

Heavy menstrual bleeding (HMB)

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

-

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Suspicion of malignancy • HMB with anaemia (Hb<85) or requiring transfusion
Category 2 (appointment within 90 calendar days)	• HMB with anaemia (Hb>85)
Category 3 (appointment within 365 calendar days)	• HMB without anaemia not responding to medical management

1. Reason for request, indicate on the referral

- To establish a diagnosis
- For treatment or intervention not otherwise accessible to the patient
- For advice regarding management
- To engage in an ongoing shared care approach between primary and secondary care
- Reassurance for GP/second opinion
- Reassurance for the patient/family
- For other reason (e.g. rapidly accelerating disease progression)

2. Essential referral information, Referral will be returned without this

- Brief description of periods
- Medical management to date
- Current cervical screening results
- FBC Serum ferritin results
- Pelvic USS (TVS preferable)
- Adolescent patient - Coag profile including von Willebrand's disease (vWD)

3. Additional referral information, Useful for processing the referral

- TSH if symptomatic of thyroid disease
- Previous management modalities, iron utilisation if deficient.

4. Request

General referral information/Standard information (Appendix 2, Consultation overview)

Notes

- Please note that where appropriate and where available, the referral may be streamed to an associated public allied health and/or nursing service. Access to some specific services may include initial assessment and management by associated public allied health and/or nursing, which may either facilitate or negate the need to see the public medical specialist.
- A change in patient circumstance (such as condition deteriorating or becoming pregnant) may affect the urgency categorisation and should be communicated as soon as possible.
- Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

5. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways and or local guidelines

A woman with heavy menstrual bleeding is referred for early specialist review when there is a suspicion of malignancy or other significant pathology based on clinical assessment or ultrasound. Link: https://www.safetyandquality.gov.au/our-work/clinical-care-standards/heavy-menstrual-bleeding/

Consider increased risk of hyperplasia or malignancy if:

- Endometrial thickness greater than 12mm (transvaginal USS ideally day 5-10)
- Irregular endometrium or focal lesion
- Weight >90kg
- PCOS / diabetes / unopposed oestrogen
- Age >45yrs
- Intermenstrual or post-coital bleeding

Medical treatment prior to or while waiting for specialist review if no suspicion of malignancy:

- Progesterone releasing IUD
- Tranexamic acid
- OCP
- NSAIDS
- Oral progestogens

Referral is also arranged for a woman who has not responded after six months of medical treatment.

Clinical resources (links)	Patient resources (links)

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

- Ensure they are aware of the request and the reason for being assessed.
- Instruct them to take all relevant radiology films and reports (including the imaging report) to appointments.
- To inform of any change in circumstance (e.g., getting worse or becoming pregnant) as this may affect the request for assessment.

Post-menopausal bleeding

(Vaginal bleeding more than 12 months following last menstrual period)

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

-

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Endometrial thickness >4mm • Cervical polyps • Suspicion of malignancy • Focal endometrial lesion
Category 2 (appointment within 90 calendar days)	• Endometrial thickness ≤4mm
Category 3	• No category 3 criteria

(appointment within 365 calendar days)	

1. Reason for request, indicate on the referral

- To establish a diagnosis
- For treatment or intervention not otherwise accessible to the patient
- For advice regarding management
- To engage in an ongoing shared care approach between primary and secondary care
- Reassurance for GP/second opinion
- Reassurance for the patient/family
- For other reason (e.g. rapidly accelerating disease progression)

2. Essential referral information, Referral will be returned without this

- History of HRT use
- Current cervical screening
- Pelvic USS (TVS preferable)

3. Additional referral information, Useful for processing the referral

- BMI

4. Request

General referral information/Standard information (Appendix 2, Consultation overview)

Notes

- Please note that where appropriate and where available, the referral may be streamed to an associated public allied health and/or nursing service. Access to some specific services may include initial assessment and management by associated public allied health and/or nursing, which may either facilitate or negate the need to see the public medical specialist.
- A change in patient circumstance (such as condition deteriorating or becoming pregnant) may affect the urgency categorisation and should be communicated as soon as possible.
- Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

5. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways and or local guidelines
- Postmenopausal women with an incidental finding on pelvic ultrasound of a regular endometrial thickness of less than 11mm and having no episodes of postmenopausal bleeding would only need a repeat ultrasound and referral if developing vaginal bleeding

Clinical resources (links)	Patient resources (links)

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

- Ensure they are aware of the request and the reason for being assessed.
- Instruct them to take all relevant radiology films and reports (including the imaging report) to appointments.
- To inform of any change in circumstance (e.g., getting worse or becoming pregnant) as this may affect the request for assessment.

Ovarian cyst / pelvic mass

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Ruptured haemorrhagic ovarian cyst
- Ovarian torsion

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Suspicious of malignancy or high-risk features: – USS findings such as solid areas, papillary projections, septations, abnormal blood flow, bilaterally or ascites – ovarian cyst >12cm – elevated CA125 and cyst >5cm in premenopausal patients or any size cyst in post-menopausal patient • Consider if significant pain and/or due to risk of torsion • Pre-pubertal patient
Category 2 (appointment within 90 calendar days)	• Persistent ovarian cyst >5cm on 2 pelvic USS 6 weeks apart • Complex cyst (haemorrhagic, endometriotic or dermoid) • Persistent pelvic pain
Category 3 (appointment within 365 calendar days)	• Hydrosalpinx

1. Reason for request, indicate on the referral

- To establish a diagnosis
- For treatment or intervention not otherwise accessible to the patient
- For advice regarding management
- To engage in an ongoing shared care approach between primary and secondary care
- Reassurance for GP/second opinion
- Reassurance for the patient/family
- For other reason (e.g. rapidly accelerating disease progression)

2. Essential referral information, Referral will be returned without this

- History including pain and other symptoms
- CA125 results (post-menopausal women)
- Pelvic USS (TVS preferable)

3. Additional referral information, Useful for processing the referral

- CA125 results (Highly desirable for pre-menopausal women)
- Family history of breast and ovarian cancer
- In paediatric and adolescent patients, remember to exclude germ cell tumours with markers: alpha feto protein LDH BHCG along with the other tumour markers

4. Request

General referral information/Standard information (Appendix 2, Consultation overview)

Notes

- Please note that where appropriate and where available, the referral may be streamed to an associated public allied health and/or nursing service. Access to some specific services may include initial assessment and management by associated public allied health and/or nursing, which may either facilitate or negate the need to see the public medical specialist.
- A change in patient circumstance (such as condition deteriorating or becoming pregnant) may affect the urgency categorisation and should be communicated as soon as possible.

- Please indicate in the referral if the patient is unable to access mandatory tests or investigations as they incur a cost or are unavailable locally.

5. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways and or local guidelines
- If cyst simple or haemorrhagic corpus luteal cyst and <5 cm repeat scan in 6 – 12 weeks
- If recurrent cysts, consider COCP or Implanon®

Clinical resources (links)	Patient resources (links)

Please insert any other information that may be of use to referring clinicians. These will be considered and incorporated into HealthPathways specialty pathways by the clinical writers.

Inform the patient

- Ensure they are aware of the request and the reason for being assessed.
- Instruct them to take all relevant radiology films and reports (including the imaging report) to appointments.
- To inform of any change in circumstance (e.g., getting worse or becoming pregnant) as this may affect the request for assessment.

Post-coital bleeding

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

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Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Suspected malignancy • SCC, positive oncogenic HPV and/or HSIL on LBC, glandular lesion on cervical screening
Category 2 (appointment within 90 calendar days)	• Post-coital bleeding recurs or persists despite negative HPV or LBC
Category 3 (appointment within 365 calendar days)	• No category 3 criteria

1. Essential referral information, Referral will be returned without this

- Findings of speculum examination
- Current cervical screening
- HVS result
- Sexual health history
- STI screen result - endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA

2. Additional referral information, Useful for processing the referral

- Pelvic USS (TVS preferable)
- Contraceptive use

3. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways and or local guidelines

- Pre-menopausal women who have a single episode of post-coital bleeding and a clinically normal cervix do not need to be referred if oncogenic HPV is not detected and LBC is negative

Clinical resources (links)	Patient resources (links)

Cervical polyp

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

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Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• SCC, positive oncogenic HPV and/or HSIL on LBC, glandular lesion on cervical screening
Category 2 (appointment within 90 calendar days)	• Cervical polyps in post-menopausal women with normal cervical screening
Category 3 (appointment within 365 calendar days)	• Cervical polyps in pre-menopausal women with normal cervical screening

1. Essential referral information, Referral will be returned without this

- Findings of speculum examination
- Current cervical screening
- Pelvic USS (TVS preferable)

2. Additional referral information, Useful for processing the referral

- HRT use

3. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways and or local guidelines
- Small endocervical polyps (<2cm) in premenopausal women with a normal cervical screening can be avulsed and sent for histology
- Cervical polyps in post-menopausal women have a higher risk of malignancy

Clinical resources (links)	Patient resources (links)

Intermenstrual bleeding

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

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Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Oncogenic HPV, LBC prediction of pHSIL/HSIL, possible high-grade glandular lesion, AIS, or invasive cancer – cervical or endometrial • Focal endometrial lesion
Category 2 (appointment within 90 calendar days)	• IMB not due to hormonal contraception • Abnormal cervical screening (other than for Cat 1) • Endometrium >12mm / irregular on pelvic USS (TVS ideally day 5-10) • Persistent and/or unexplained IMB
Category 3 (appointment within 365 calendar days)	• IMB bleeding related to hormonal contraception that is not responding to medical management e.g. contraception manipulation

1. Essential referral information, Referral will be returned without this

- History of abnormal bleeding / hormonal contraceptive use
- Current cervical screening
- HVS result
- BHCG result
- STI screen result – endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA
- Pelvic USS (TVS preferable)

2. Additional referral information, Useful for processing the referral

-

3. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways and or local guidelines

Clinical resources (links)	Patient resources (links)
• Reference material – RANZCOG, Investigation of intermenstrual and post coital https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women's%20Health/Statement%20and%20guidelines/Clinical%20-%20Gynaecology/Investigation-of-intermenstrual-and-postcoital-bleeding-(C-Gyn-6)-Review-March-2015.pdf?ext=.pdf	

Primary/ secondary amenorrhoea

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

-

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• Primary amenorrhoea
Category 3 (appointment within 365 calendar days)	• Secondary amenorrhoea

1. Essential referral information, Referral will be returned without this

- Duration of amenorrhoea (i.e. >6 months)
- Weight/ BMI
- BHCG results
- FSH LH prolactin oestradiol TSH results
- TAS – TVS USS may not be appropriate in non-sexually active females, therefore important to seek early advice from state-wide paediatric and adolescent gynaecology (SPAG) service

2. Additional referral information, Useful for processing the referral

- Renal USS

3. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways and or local guidelines
- Primary amenorrhoea – is defined as the absence of menses at age 16 years in the presence of normal growth and secondary sexual characteristics and 14 in the absence of secondary sexual characteristics
- Secondary amenorrhoea – absence of menses for more than six months after the onset of menses
- Refer to state-wide paediatric and adolescent gynaecology (SPAG) services at LCCH/RBWH
- Address excessive exercise or dieting
- If BMI is greater than 30, manage weight loss
- Address any significant stress or anxiety
- Review medications if relevant (e.g. antipsychotics, metoclopramide)
- Cyclical abdominal pain in adolescent with primary amenorrhoea might be indication of imperforate hymen

Clinical resources (links)	Patient resources (links)

Pelvic pain/dysmenorrhea/PMS

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Acute/severe pelvic pain

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Suspicion of malignancy
Category 2 (appointment within 90 calendar days)	• Multiple emergency presentations

	• Pelvic pain and significant USS findings e.g. presence of endometriomas / fixed retroverted uterus
Category 3 (appointment within 365 calendar days)	• Chronic pain not responding to maximal medical management

1. Essential referral information, Referral will be returned without this

- History of/to:
  - pain, severity and duration, cyclical nature, dysmenorrhoea
  - differentiate from GI pain
  - previous sexual abuse, PID
- Current cervical screening
- HVS result
- STI screen result – endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA
- MSU M/C/S result
- Pelvic USS (TVS preferable)

2. Additional referral information, Useful for processing the referral

-

3. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways and or local guidelines
- Medical management
  - Important to exclude cyclical bladder, bowel symptoms
  - Treat infection if present
  - Simple analgesia
  - Suppress menstrual cycle with oral contraceptive pill / implanon® / depo-provera / mirena®
  - Treat dysmenorrhoea with NSAIDS or COCP

Clinical resources (links)	Patient resources (links)

Pelvic floor dysfunction (e.g. prolapse and/or incontinence)

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Acute urinary obstruction

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Uterine procidentia • Difficulty voiding with renal impairment
Category 2 (appointment within 90 calendar days)	• Difficulty voiding +/- significant residuals on bladder screening (without renal impairment) • Recurrent UTIs • Genital fistulae • Mesh erosion or bleeding/pain

Category 3 (appointment within 365 calendar days)	• Any other prolapse or incontinence • Obstructed defecation

1. Essential referral information, Referral will be returned without this

- Obstetric and gynaecological history
- History of:
  - prolapse symptoms
  - protruding lump
  - dragging sensation
  - difficulty with defecation (requiring manual evacuation) / micturition including incontinence
- MSU M/C/S results

2. Additional referral information, Useful for processing the referral

- Previous failed or complicated prolapse surgery
- Pelvic USS (TVS preferable) if available
- Bladder diary
- Renal USS if major uterine procidenta

3. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways and or local guidelines
- Medical management:
  - Consider referral to women's health physiotherapist for the following:
    - prolapse – consider pessary.
    - stress incontinence – physiotherapist for pelvic floor exercises and bladder retraining for 3 months prior to referral
    - urinary urgency - exclude infection
  - Consider trial of anticholinergics.
  - Treat constipation
  - Consider topical oestrogen in post-menopausal women
  - Lifestyle modification (Increased activity, dietary, weight, smoking, alcohol)

Clinical resources (links)	Patient resources (links)
• Link to mesh clinic Gold Coast • https://www.ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Media%20Centre/Mesh-removal-in-Australia.pdf •	Urogynaecologist society of Australasia – Patient information http://www.ugsa.org.au/pages/patient-information.html

Fibroids

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

•

Minimum referral criteria

Category 1	• Suspicion of degeneration or malignancy

(appointment within 30 calendar days)	• Urinary obstruction, renal impairment e.g. hydroneprhosis, history of urinary retention • Heavy Menstrual Bleeding (HMB) with anaemia (Hb<85) or requiring transfusion • Fibroid prolapse through cervix
Category 2 (appointment within 90 calendar days)	• Pressure symptoms (such are ureteric impingement) • HMB with anaemia (Hb>85) • Abdominal discomfort
Category 3 (appointment within 365 calendar days)	• HMB without anaemia not responding to maximal medical management • Fibroids and reproductive issues

1. Essential referral information, Referral will be returned without this

- History of:
  - symptoms
  - Heavy menstrual Bleeding (HMB), brief description of periods, medical management to date
  - dragging sensation
  - urinary frequency
- Current Cervical screening results
- FBC iron studies results
- Pelvic USS (TVS preferable)

2. Additional referral information, Useful for processing the referral

-

3. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways and or local guidelines
- If asymptomatic (e.g normal menstrual pattern, normal Hb, post-menopausal), there is no need for referral

Clinical resources (links)	Patient resources (links)

Known or suspected endometriosis

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

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Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• Multiple emergency presentations • Endometriomas on USS • Endometriosis/chronic not responding to maximal medical management • Associated bowel or bladder disturbance
Category 3 (appointment within	• Endometriosis and reproductive issues

365 calendar days)	

1. Essential referral information, Referral will be returned without this

- Medical management to date/surgical history
- History of pain and menstruation
- Symptoms
  - dysmenorrhoea
  - deep dyspareunia
  - dyschezia
- History of sub-fertility
- Pelvic USS results (TVS preferable)

2. Additional referral information, Useful for processing the referral

- Menstrual diary (if available)

3. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways and or local guidelines

Clinical resources (links)	Patient resources (links)

Infertility / RPL

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

-

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• Reproductive counselling for fertility sparing options prior to chemotherapy treatment • All other Category 1 referral for infertility are not accepted, refer to a private specialist to avoid delay
Category 2 (appointment within 90 calendar days)	• Category 2 referral for infertility not accepted, refer to a private specialist to avoid delay
Category 3 (appointment within 365 calendar days)	• All referrals for infertility for example but not limited to: – surgical management of hydrosalpinx – anovulation for ovulation induction (selected cases) – unexplained infertility (selected cases) – recurrent pregnancy loss (definition: - infertility is the failure to achieve pregnancy after 12 months or more of regular unprotected intercourse)

1. Essential referral information, Referral will be returned without this

- History of
  - previous pregnancies, STDs and PID, surgery, endometriosis
  - other medical conditions

- Weight/ BMI
- FBC Group and antibodies Rubella IgG Varicella IgG, Syphilis Serology, HBV/HCV/HIV serology results
- Day 21 serum progesterone level (7 days before the next expected period)
- FSH, LH (Day 2-5), Prolactin, TSH if cycle prolonged and/or irregular
- STI screen result – endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA
- Pelvic USS (TVS preferable)
- Suspicion of PCOS include the following:
  - SHBG results
  - Testosterone, DHEA-S results
  - Fasting blood glucose results
  - Lipids, TSH results
- Include a referral with the following information for the partner
  - age and health, reproductive history, testicular conditions, seminal analysis result

2. Additional referral information, Useful for processing the referral

- History of marijuana use (including partner)
- Fasting blood glucose, testosterone and free androgen index test for those likely to have PCOS
- Hysterosalpingography (HSG) or saline infusion USS (sonohysterography)

3. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways and or local guidelines
- Treatment is as a couple and requires a partner referral
- IVF not available in public hospitals
- To assess tubal patency, consider Hysterosalpingography (HSG) or saline infusion USS (sonohysterography) if history suggestive of blocked fallopian tubes
- Seminal analysis of partner (≥4 days of abstinence). Repeat in 4-6 weeks if abnormal.
- Lifestyle modification (increased activity, dietary, weight, smoking, alcohol)
  - simple moderate physical activity including structured exercise (at least 30 minutes/day) and optimising incidental exercise assists with weight loss and weight maintenance
  - achieve optimal weight BMI 20 – 30
  - referral to dietician
- **Infertility**: Folic acid 0.5mg/day

Clinical resources (links)	Patient resources (links)

Vulva lesion/lump/genital warts/boil/swelling/abscess/ulcer/bartholin's cyst

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Bartholin's abscess / acute painful enlargement of a Bartholin's gland/cyst

Minimum referral criteria

Category 1 (appointment within	• Vulval disease with suspicion of malignancy • Unexplained vulval lump, ulceration or bleeding

30 calendar days)	• Post-menopausal women with abnormal vulval lesion • Pregnant or immunosuppressed
Category 2 (appointment within 90 calendar days)	• Suspected vulval dystrophy • Bartholin's cysts or other vulval cysts in patients >40 years old • Vulval warts where: – the patient is immunocompromised (e.g. HIV positive, immunosuppressant medications) – the diagnosis is unclear – atypical genital warts (including pigmented lesions) – there are positive results from the screen for other STI's.
Category 3 (appointment within 365 calendar days)	• Vulval lesion where: – there is treatment failure or where treatment cannot be tolerated due to side-effects – there are problematic recurrences • Vulval rashes • Vulval warts • Bartholin's cyst/labial cysts

1. Essential referral information, Referral will be returned without this

- History of:
  - Pain, swelling
  - pruritus
  - dyspareunia
  - localised lesions (pigmented or non-pigmented lesions)
  - STIs or other vaginal infections
  - local trauma
- Elicit onset, duration and course of presenting symptoms
- Date of last menstrual period
- Medical management to date
- Cervical screening if referral for warts

2. Additional referral information, Useful for processing the referral

- Vulva ulcers – swab M/C/S and viral PCR result
- Vulval rashes – scraping, swaps or biopsy (as appropriate)
- STI screen result -endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA (as appropriate)
- Syphillis HIV serology (as appropriate)

3. Other useful information for referring practitioners, not an exhaustive list

- For paediatric and adolescent gynaecology patients, please refer to state-wide paediatric and adolescent gynaecology (SPAG) services at LCCH/RBWH
  - <14 years refer to LCCH
  - >14 years refer to RBWH or local adolescent gynae service
- Antibiotic treatment of Bartholins cyst is of no value.
- In women where a vulval cancer is strongly suspected on examination, urgent referral should not await biopsy.
- Vulval cancers may present as unexplained lumps, bleeding from ulceration or pain.

- Vulval cancer may also present with pruritus or pain. For a patient who presents with these symptoms and where cancer is not immediately suspected, it is reasonable to use a period of 'treat, watch and wait' as a method of management. However, this should include active follow-up until symptoms resolve or a diagnosis is confirmed. If symptoms persist, the referral may be urgent or non-urgent, depending on the symptoms and the degree of concern about cancer.

Clinical resources (links)	Patient resources (links)

Dyspareunia (deep or superficial)

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• No category 1 criteria
Category 2 (appointment within 90 calendar days)	• Severe pelvic pain associated with dyspareunia
Category 3 (appointment within 365 calendar days)	• Vulvodynia/Vulvar vestibulitis syndrome

1. Essential referral information, Referral will be returned without this

- History of:
  - nature of the pain – location, intermittent or persistent
  - general body muscle tensing and general or focal pelvic floor muscle tension before and during attempts at penetration
  - medical, surgical and obstetric history
- Pelvic USS results (TVS preferable)

2. Additional referral information, Useful for processing the referral

- STI screen result – endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA
- HVS M/C/S and viral PCR result

3. Other useful information for referring practitioners, not an exhaustive list

- Refer to HealthPathways and or local guidelines
- Advise using lubricant and adequate foreplay prior to intercourse
- For superficial dyspareunia: (consider referral to women's health physiotherapist)
  - breast feeding women – consider topical oestrogen
  - consider vaginismus and referral to a sexual medicine service
  - consider psychosocial issues and referral for counselling

Clinical resources (links)	Patient resources (links)
Sexual health services in Queensland	

https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/sex-health/services/find-service	

Mirena®/progesterone releasing IUD Insertion or removal

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

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Minimum referral criteria

Category 1 (appointment within 30 calendar days)	• HMB with anaemia (Hb<85) or requiring transfusion
Category 2 (appointment within 90 calendar days)	• HMB with anaemia (Hb>85)
Category 3 (appointment within 365 calendar days)	• HMB without anaemia not responding to maximal medical management • Contraception (if clinically indicated) • HRT • Replacement Mirena®/ progesterone releasing IUD (if clinically indicated) • Mirena®/ progesterone releasing IUD Insertion or removal (if clinically indicated) NB: Routine Mirena®/progesterone-releasing IUD insertion for contraception **may be** out-of-scope for certain Gynaecology services.

1. Essential referral information, Referral will be returned without this

- Medical history - relevant family history, menstrual, obstetric, contraceptive, and sexual history
- Current cervical screening
- Mirena® prescription (The local service may require the referring GP to provide a prescription for the device to the patient who **must** bring the device with her to the clinic)

2. Additional referral information, Useful for processing the referral

- Pelvic USS if lost strings, HMB or other clinical indication
- STI screen result – endocervical swab or first catch urine for chlamydia +/- gonorrhoea NAA

3. Other useful information for referring practitioners, not an exhaustive list

- The local service may require the referring GP to provide a Mirena® prescription for the device to the patient who **must** bring the device with her to the clinic.
- For paediatric and adolescent gynaecology patients please refer to state-wide paediatric and adolescent gynaecology (SPAG) services at LCCH/RBWH
- Where available for the routine removal or insertion of Mirena®/progesterone releasing IUD please consider referral to True – relationships and reproductive health (formerly known as Family Planning Queensland) or a Women's Health speciality primary care provider who may be able to provide this service in their own clinic.

Clinical resources (links)	Patient resources (links)
	True link

Other referrals to emergency not covered within these conditions

Referral to emergency

If any of the following are present or suspected, refer the patient to the emergency department (via ambulance if necessary) or seek emergent medical advice if in a remote region.

- Ectopic pregnancy
- Ruptured haemorrhagic ovarian cyst
- Torsion of uterine appendages
- Acute/severe pelvic pain
- Significant or uncontrolled vaginal bleeding
- Severe infection
- Abscess intra pelvis or PID
- Bartholin's abscess / acute painful enlargement of a Bartholin's gland/cyst
- Acute trauma including vulva/vaginal lacerations, haematoma and/or penetrating injuries
- Post-operative complications within 6 weeks including wound infection, wound breakdown, vaginal bleeding/discharge, retained products of conception post-op, abdominal pain
- Urinary retention
- Molar pregnancy
- Inevitable and / or incomplete abortion
- Hyperemesis gravidarum
- Ascites, secondary to known underlying gynaecological oncology

Intervention criteria

Out-of-scope for Gynaecology interventions

Not all services are funded in the Queensland public health system. Exceptions can always be made where clinically indicated. It is proposed that the following are not routinely provided in a public Gynaecology service:

Exclusion criteria include the following:

- Elective cosmetic surgery e.g. labiaplasty

NB labial hypertrophy in paediatric and adolescent patients: refer to Statewide Paediatric and Adolescent Gynaecology services (SPAG) at LCCH/RBWH

- Elective tubal ligation but will be accepted as a category 3, if:
  - patient cannot use/trialled other contraceptive methods
  - patient does not want to pass on any genetic disorders or disabilities
  - indicated for women suffering from medical or obstetric conditions that would contraindicate future pregnancy.
- Contraception e.g. Implanon
- Routine Mirena®/progesterone releasing IUD insertion for contraception
- Primary menopausal care
- Screening pap smear
- Postnatal check-up

NB Where available recommend referral to True – relationships and reproductive health (formerly known as Family Planning Queensland) or Women's Health speciality primary care provider/service

- Elective termination of pregnancy
- IVF services
- Reversal of tubal ligation

Urgency category for intervention

Intervention	Minimum Criteria	Urgency
Colposcopy	• High grade cervical squamous lesions on cervical screening • Any glandular cervical lesion suspected on cervical screening biopsy • Abnormal smear or concern regarding appearance of cervix, vagina or vulva	Cat 1 *Cat 2 – National Elective Surgery Categoristion*
Hysteroscopy, dilation and curettage	• Endometrium ≥ 12 mm and the Pipelle sample are inadequate or there is a suggestion of polyps	Cat 2
Cone biopsy		Cat 1

Endometrial Ablation		Cat 3
Laparoscopy for dye studies / endometriosis		Cat 3
LLETZ		Cat 2
Mirena® insertion		Cat 3
Myomectomy		Cat 3
Stress incontinence surgery		Cat 3

Version control

Version	Date	Author	Nature of amendment
v0.01		CPC team (Liz Travers, Lana Conde)	Initial version
v0.02-v0.17		Dr Bob Baade, CAG, CPC team (Liz Travers, Lana Conde)	CAG consultation
v0.18	30/03/2016	CPC team (Liz Travers, Lana Conde)	Transfer into 'phase 2' consultation template and editorial review
v0.19	27/04/2016	Dr Bob Baade, CPC team (Liz Travers, Lana Conde)	Minor amendments following meeting with Dr Bob Baade
v0.20	20/05/2016	Dr Bob Baade, CAG, CPC team (Liz Travers, Lana Conde)	Minor amendments following final endorsement with CAG
V1.0	24/05/2016	CPC team (Liz Travers, Lana Conde)	Final endorsed CPC
V1.1	14/07/2016	CPC Team, Bob Baade, Anton Marineanu	Amendment of pelvic prolapse and incontinence to Pelvic floor dysfunction criteria
V1.2	04/05/2017	CPC Team (Liz Travers)	Amendments from multiple feedback
V1.3	15/02/2018	CPC Team (Liz Travers)	Amendments to cervical screening
V1.4	29/06/2018	CPC Team (Liz Travers)	Amendments from publishing CPC and review CPC
V1.5	2/8/2018	Clinical Advisory Group	Post CPC review meeting with amendments and rebranding