

City and Hackney GP Community Gynaecology Education Event – 26th February 2021

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Community Gynaecology Service

The Ivy Centre
St Leonard's Hospital
Nuttall Street


- Average of 4 weekly sessions
- Consultants: Dr Sue Mann, Dr Priyanka Patel and Dr Jane Thomas
- Pilot PCN (Hackney Marshes) bimonthly clinic starting in April by Sue Mann



Conditions Seen

- HMB
- Intermenstrual /Postcoital bleeding
- Amenorrhoea
- Dysmenorrhoea
- Advice regarding Fibroids or Adenomyosis if patient does not require/desire surgery
- Menopause and HRT
- PMS
- PCOS
- Pelvic pain
- Vulval and vaginal symptoms including patient concern about appearance of external genitalia
- Cervical polyps
- Cervical ectropion
- Abnormal looking cervix
- Difficult cervical smear
- Difficult IUS insertions and removals if for HMB
- Counselling regarding LARC vs. sterilisation
- Fertility advice

Previously:

- Postmenopausal bleeding: Now refer to HUH (2 WW)
 - Utero-vaginal prolapse: Now refer to HUH vaginal ring pessary service
 - Psychosexual problems: Now HSHS Service
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Case 1:SS

- 34 year old
- Secondary amenorrhoea > 1 year and before this periods were irregular every 3-4 months
- Periods stopped on gaining weight
- Glucose intolerance
- No regular meds
- Smear is due, negative in past



Case 1:SS continued...

- P0
- RMP, condoms
- No hx STIs
- BMI 41.3
- Trying to lose weight

- On questioning...history of hirsutism



Rotterdam diagnostic criteria for PCOS

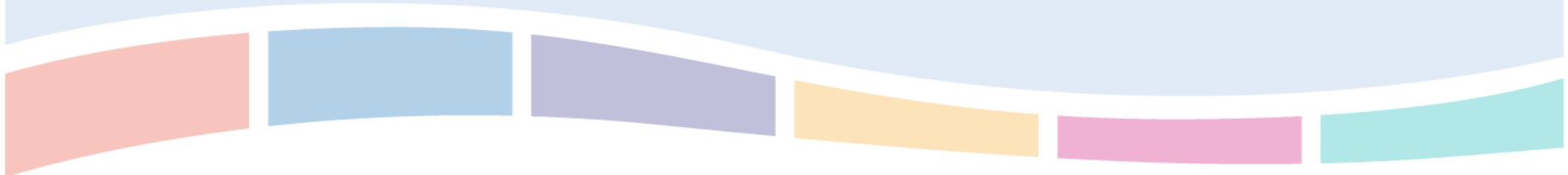
Two of the following three criteria:

- Oligo/anovulation
- Hyperandrogenism
 - Clinical (hirsutism or less commonly male pattern alopecia)
 - Or biochemical (raised FAI or free testosterone)
- Polycystic ovaries on ultrasound



Differential Diagnosis

- Other aetiologies must be excluded such as congenital adrenal hyperplasia, androgen secreting tumours, Cushing syndrome, thyroid dysfunction and hyperprolactinaemia



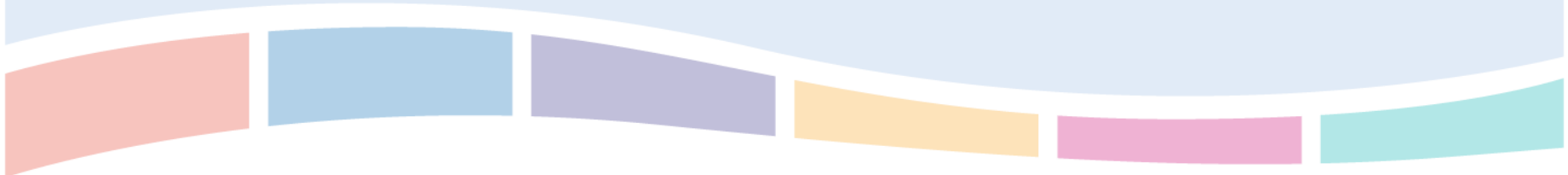
Longterm Implications

- Fertility implications and potential need for ovulation induction when she wants a pregnancy
- The need for 3-4 bleeds/year to protect endometrium
- The association with increased risk of metabolic syndrome and long-term health consequences: the increased risk of Type 2 diabetes/CVD and importance of controlling risk factors. The importance of maintaining a recommended BMI, exercise and a healthy diet



Longterm Screening

- Consider screening for gestational diabetes at 24-28 weeks gestation
- BMI>25 or BMI<25 with additional RFs (age >40, hx gestational DM/ FH DM): GTT
- Prevalence of OSA increased in high BMI
- Assessing CVD RFs – obesity, lack of physical activity, smoking, FH, hypertension, raised cholesterol, DM
- Screen for depression/anxiety



Endometrial Protection

- Need for 3-4 bleeds/year to protect endometrium
- Women with PCOS have a nearly 3 x increased risk of developing endometrial cancer
- Intermenstrual intervals of more than 3 months are associated with endometrial hyperplasia
- Regular induction is required with at least 12 days of progestogens (for example Provera 10 to 30 mg at night), oral contraceptives or the levonorgestrel-IUS
- Endometrial assessment needs to be considered if her endometrial thickness is more than 7 mm



Metformin and fertility

- No strong evidence regarding longterm benefits in PCOS
- Ltd role in improving reproductive outcomes in specific patient groups, for example in obese women when combined with clomiphene, those with clomiphene citrate resistance, and IGT or type II diabetes
- Unpleasant SEs e.g. nausea, vomiting, abdominal pain, diarrhoea, dizziness and tiredness
- Most common regimens: 500 mgs TDS/ 850mg BD
- Lifestyle advice remains mainstay

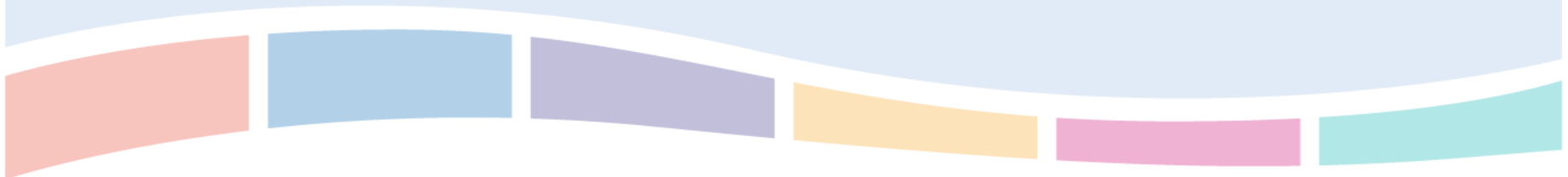


Plan

- SS has recently lost 6 kg which I strongly encouraged
 - Lifestyle changes, including diet, exercise and weight loss is first line treatment
- Consider the Mirena IUS for endometrial protection.
COCP CI due to BMI
- Up-to-date pelvic ultrasound scan
- F2F review: smear test, Mirena IUS and Pipelle biopsy if indicated
- GP advised to prescribe some progestogens (Provera) in the meantime

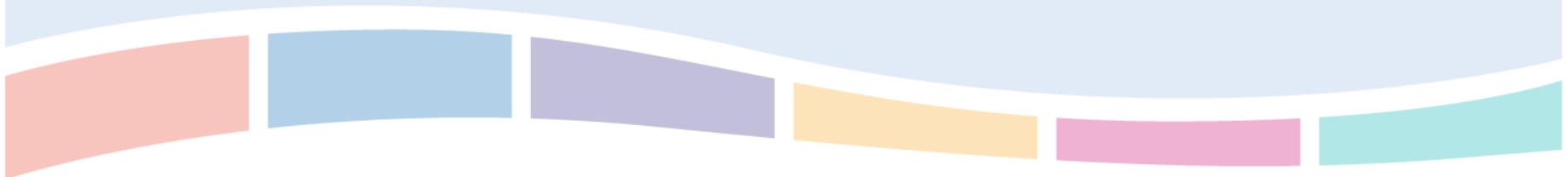
Investigations

- Pelvic USS showed multifollicular ovaries suggestive of PCO
- Thin endometrium




Case 2:KK

- 36 year old
- Heavy, irregular and infrequent periods
- 4 periods in the year

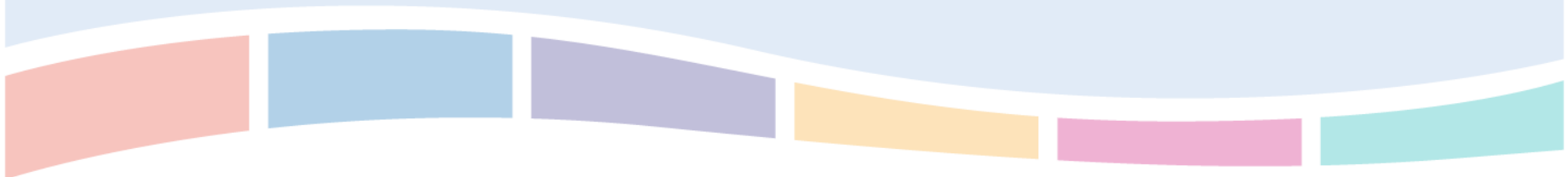


Case 2: KK, Background

- LMP 3/12 ago
 - Para 0 + 0
 - RMP, her husband, no contraception
 - Last STI test negative in 2019
 - Smears: UTD and negative
 - Gynaecological hx: Nil significant
 - Medical/Surgical hx: Nil significant
 - Medications: Nil
 - Lives with: Husband
 - Occupation: Textile designer
 - Smokes 5-10/day
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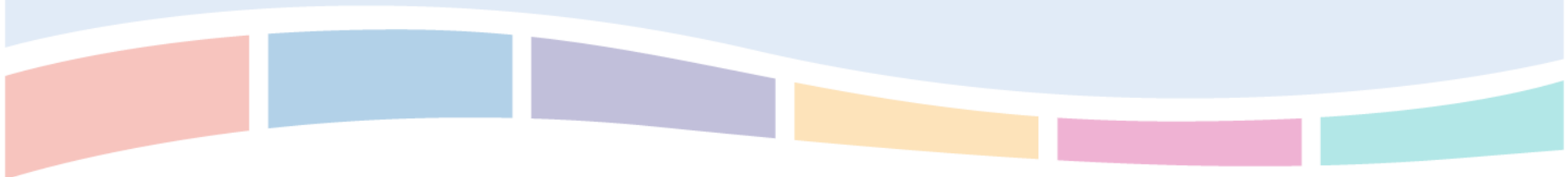
On further questioning...

- Struggling with hot flushes, low mood, loss of hair and gained weight in the past 6 months
- Really anxious something is wrong



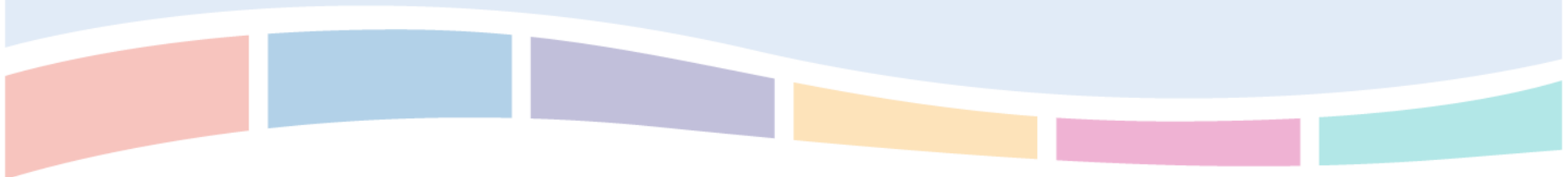
Investigations

- FSH 50.5, LH 29.1, oestradiol 249
- Cursory pelvic ultrasound scan in community gynaecology: NAD
- Blood tests and pelvic ultrasound scan were normal last year



Repeat blood tests

- FSH 59 and LH 26
- Oestradiol 158
- Has stopped smoking



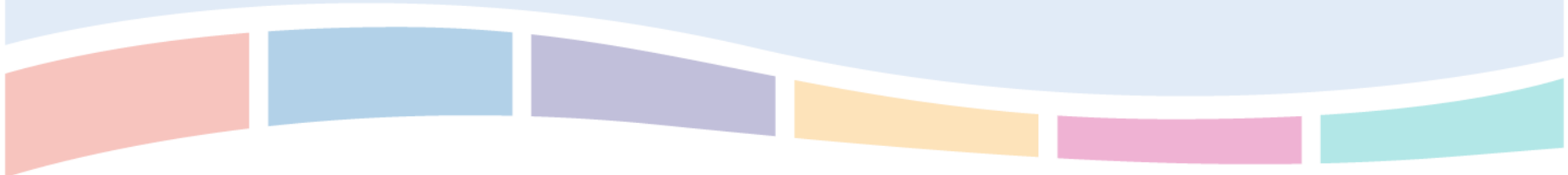
Diagnosis

- Premature Ovarian Insufficiency (POI)
 - Oligomenorrhoea/amenorrhoea of more than 4 months' duration associated with elevated gonadotropins (FSH >40 iu/l) on at least two occasions measured 4-6 weeks apart in women < 40



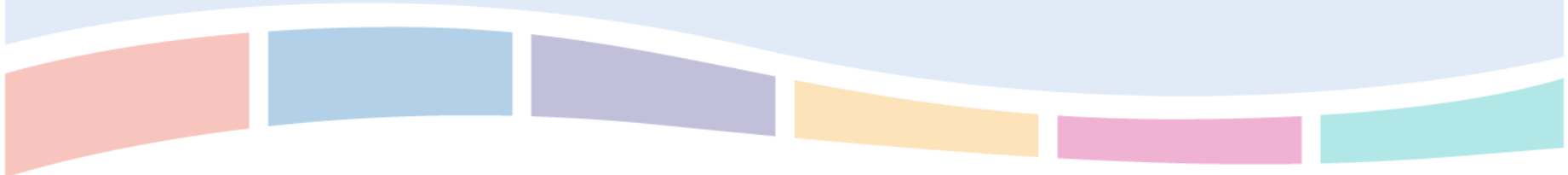
Investigations to consider

- Screening for underlying endocrinological disorders such as thyroid dysfunction and type 1 diabetes
- Thyroid dysfunction has been associated with up to 30% of cases of POI
- Transvaginal ultrasound: small ovaries with minimal follicular activity



Risk OP

- RFs for osteoporosis
- Baseline bone density scan
- Decreases in bone density parallel decreases in ovarian function; by the time cessation of ovarian function is confirmed, bone density may already be significantly affected



Premature Ovarian Insufficiency (POI)

- Increased risk of cardiovascular disease, osteoporosis and cognitive impairment
- HRT will likely lower the longterm risk of CVD, prevent OP and benefit cognitive function
- COCP is reasonable alternative and provides contraception but HRT is likely to be better for bone health and have a better blood pressure/CVD profile
- Limited evidence regarding optimal regimen



POI & HRT, Risk of breast CA

- Women with POI seem to have a lower risk of breast cancer compared with controls
- HRT does not increase the risk of breast cancer in younger menopausal women < age 50
- But the Lancet study 2019: starting HRT age 40 - 50 was also associated with an increased risk but women in this sub-group was relatively small
- Raised BMI and increased alcohol raise risk more than HRT



POI & HRT, Risk of VTE

- Transdermal estradiol is unlikely to increase the risk of VTE
- Use transdermal route in women with POI who are at increased risk of VTE (including high BMI)
- Continue HRT until natural age of menopause
- HRT is not contraception



Management: Lifestyle Advice and bone health

- Smoking cessation and avoidance of excessive alcohol intake
- Benefits of exercise and a healthy, balanced diet
- Importance of an adequate calcium and Vitamin D intake



POI: Fertility

- Can have intermittent ovarian activity and have a chance of natural conception of 5-10%
- Fertility techniques using the woman's own eggs are unlikely to be successful
- The most effective intervention =
Oocyte donation
- Oocyte/embryo cryopreservation or ovarian tissue cryopreservation are unlikely to be successful



Case 2: KK, Management

- Oestrogel and Utrogestan (micronised progesterone)
- POI may require higher doses of oestrogen than older women (3-4 doses of E2 gel)
- Data is lacking regarding the optimal estradiol levels for prevention of long term sequelae
- Aim for physiological levels of estradiol.
If any need for monitoring then aim for 300-500 pmol/L mid follicular levels



Case 2, KK

- Daisy Network for further information
- Understandably distressed at diagnosis but also relieved she had an explanation for her symptoms....



Thank you

