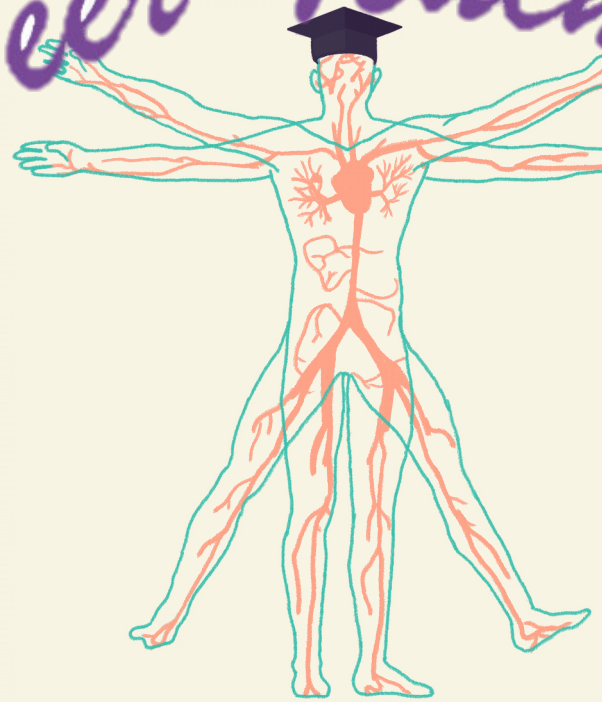
Peer Teaching



Society

2023/2024

Obs & Gynae 2 + Sexual Health

Phase 3A Revision Session

Emily Finbow

29/11/2023 : 6pm

Aims and Objectives

- Case-based approach, range of o&g presentations
- Practice MCQs + SAQs

…it is impossible to cover all of o&g + sexual health in one evening, I have picked a few areas!

Pre-Warnings

* For the purpose of this session, the words ‘women’ and ‘female’ will be used to describe people who are assigned female at birth / have female reproductive organs *

The topics I have picked should not be too triggering or sensitive but cancer / miscarriage / abortion / stillbirth / fertility problems may be discussed

Obstetrics and gynaecology

Presentations
Abdominal distension
Abdominal mass
Abnormal cervical smear result
Abnormal urinalysis
Acute abdominal pain
Acute and chronic pain management
Amenorrhoea
Bleeding antepartum
Bleeding postpartum
Breast tenderness/pain
Breathlessness
Chest pain
Complications of labour
Contraception request/advice
Difficulty with breast feeding
Fits/seizures
Headache
Hypertension
Hyperemesis
Intrauterine death
Jaundice
Labour
Loss of libido
Menopausal problems
Menstrual problems
Mental health problems in pregnancy or postpartum
Nipple discharge
Normal pregnancy and antenatal care
Painful sexual intercourse
Painful swollen leg
Pelvic mass
Pelvic pain
Pregnancy risk assessment
Pruritus
Reduced/change in fetal movements
Shock
Small for gestational age/ large for gestational age
Subfertility
Substance misuse
Unwanted pregnancy and termination
Urethral discharge and genital ulcers/warts
Urinary incontinence
Urinary symptoms
Vaginal discharge

Conditions
Anaemia
Atrophic vaginitis
Bacterial vaginosis
Cervical cancer
Cervical screening (HPV)
Chlamydia
Cord prolapse
Depression
Diabetes in pregnancy (gestational and pre-existing)
Ectopic pregnancy
Endometrial cancer
Endometriosis
Epilepsy
Essential or secondary hypertension
Fibroids
Gonorrhoea
Menopause
Obesity and pregnancy
Ovarian cancer
Pelvic inflammatory disease
Placenta praevia
Placental abruption
Postpartum haemorrhage
Pre-eclampsia, gestational hypertension
Sepsis
Substance use disorder
Syphilis
Termination of pregnancy
Trichomonas vaginalis
Urinary incontinence
Urinary tract infection
Varicella zoster
Vasa praevia
VTE in pregnancy and puerperium

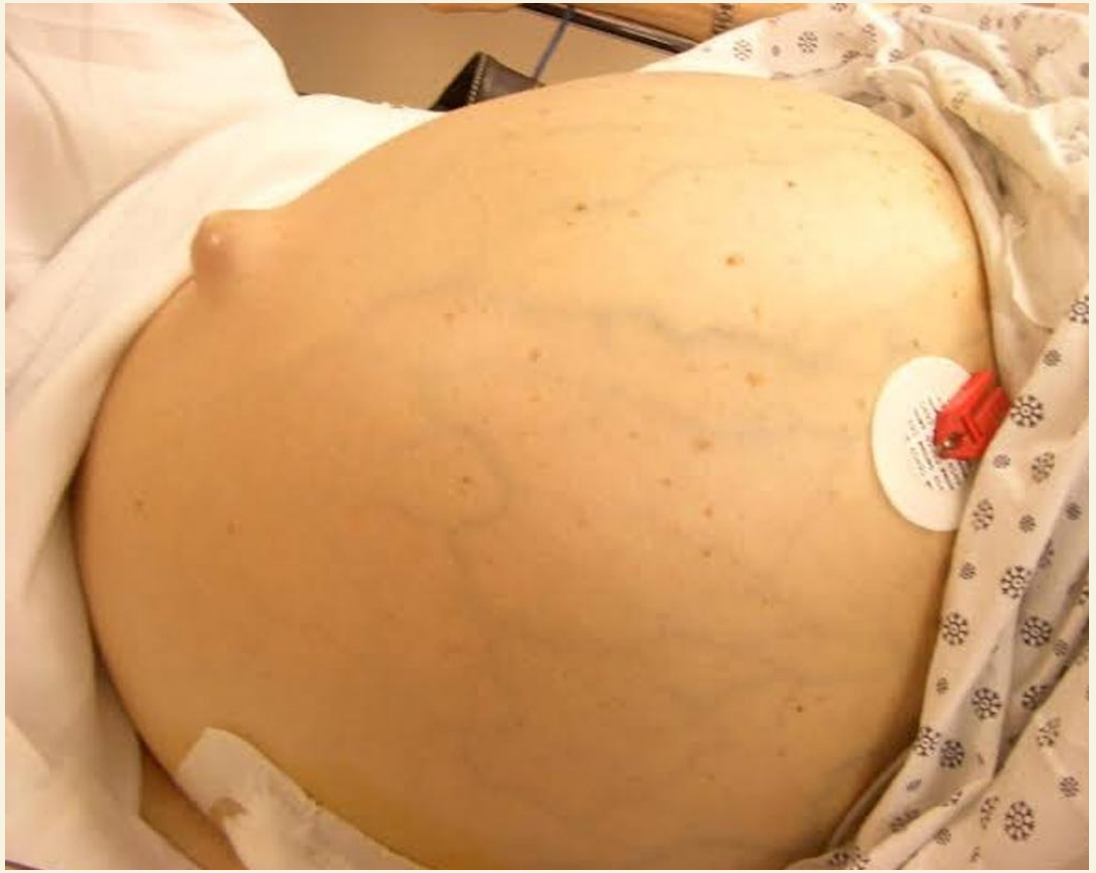
https://www.gmc-uk.org/-/media/documents/mla-content-map-_pdf-85707770.pdf : pg 33

Today's Plan:

1. Distended Abdomen
2. Abnormal Bleeding
3. Irregular Periods
4. Infertility
5. Gestational Diabetes
6. Infection in Pregnancy
7. Vaginal Discharge
8. Missed Pill

1: Distended Abdomen

Carol is a 64 year old lady. She arrives to A&E uncomfortable and ‘bloated’
She says she doesn’t like going to the doctors and hasn’t been for over a year.
O/E her abdomen is tense and distended
She has no other features in keeping with liver disease



On specific questioning, her bowels have been a bit “erratic” and she has lost a significant amount of weight. She is a smoker of 45 years and drinks very occasionally.

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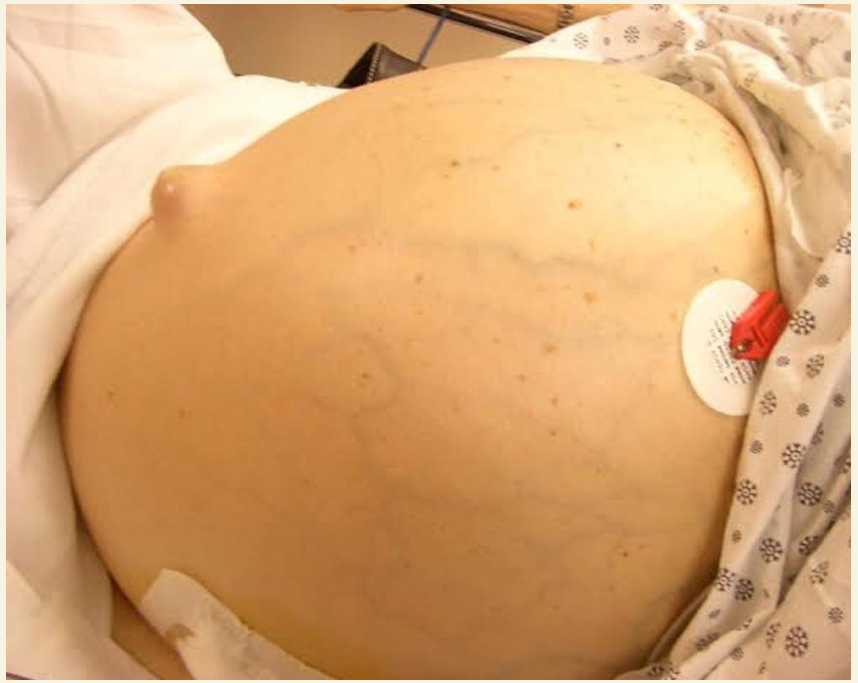

and drinks alcohol very occasionally.

Name 3 protective factors for the most likely differential (3 marks)

What specific blood test should be requested? (1 mark)

What imaging should be requested? (1 mark)

uld her distended abdomen be managed? (2 marks)

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Multiparity

Combined contraceptive methods (COCP)

Breastfeeding

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easing the number of ovulations that happen

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CA125

(and we’re expecting it to be raised)

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(and we’re expecting it to be raised) - although there are other non-malignant causes of raised CA125 inc endometriosis, fibroids, liver disease, pregnancy etc

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What imaging should be requested? (1 mark)
transabdominal and transvaginal pelvic USS

(CXR + CT abdomen/pelvis for staging once cancer confirmed)

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How should her distended abdomen be managed? (2 marks)
Drain the fluid = 1 mark
Send sample for cytology analysis = 1 mark

Ovarian Cancer - 5 (other) key facts

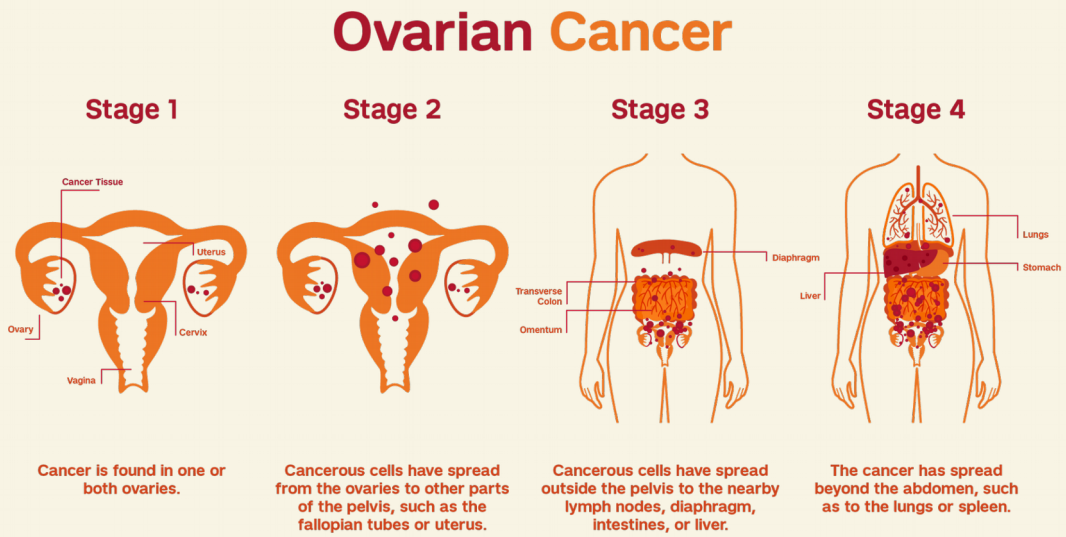
1. **BRCA mutations** are a major risk factor

2. Epithelial cell tumours are the most common type - most common subtype = **serous tumours**

3. Presents with **non-specific symptoms**, including abdominal bloating, early satiety, pelvic pain, urinary symptoms, weight loss, IBS-like symptoms

4. **Risk of malignancy index** (RMI) estimates risk of ovarian mass being malignant: menopausal status, USS findings, CA125 level

) staging system used to stage ovarian ca: 1- 4

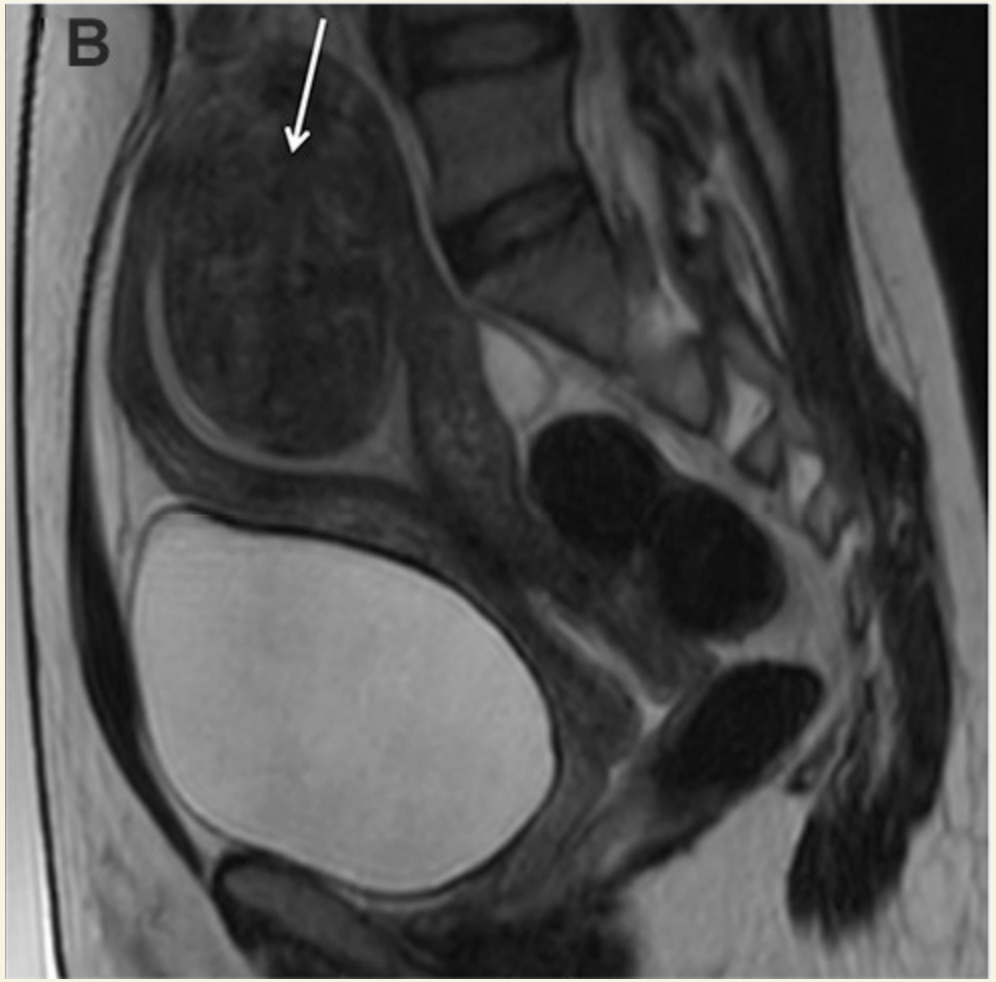


2: Abnormal Bleeding

A patient has attended for gynaecology review post-MRI scan.

Which of the following is not true about the specific pathology shown in the scan?

A. They are oestrogen sensitive
B. Menorrhagia is the most frequent presenting symptom
C. She has a subserosal fibroid
D. Malignant change is unlikely
E. Uterine artery embolisation may be an appropriate management option



https://www.dovepress.com/effect-of-magnetic-resonance-imaging-characteristics-on-uterine-fibroi-peer-reviewed-fulltext-article-RMI

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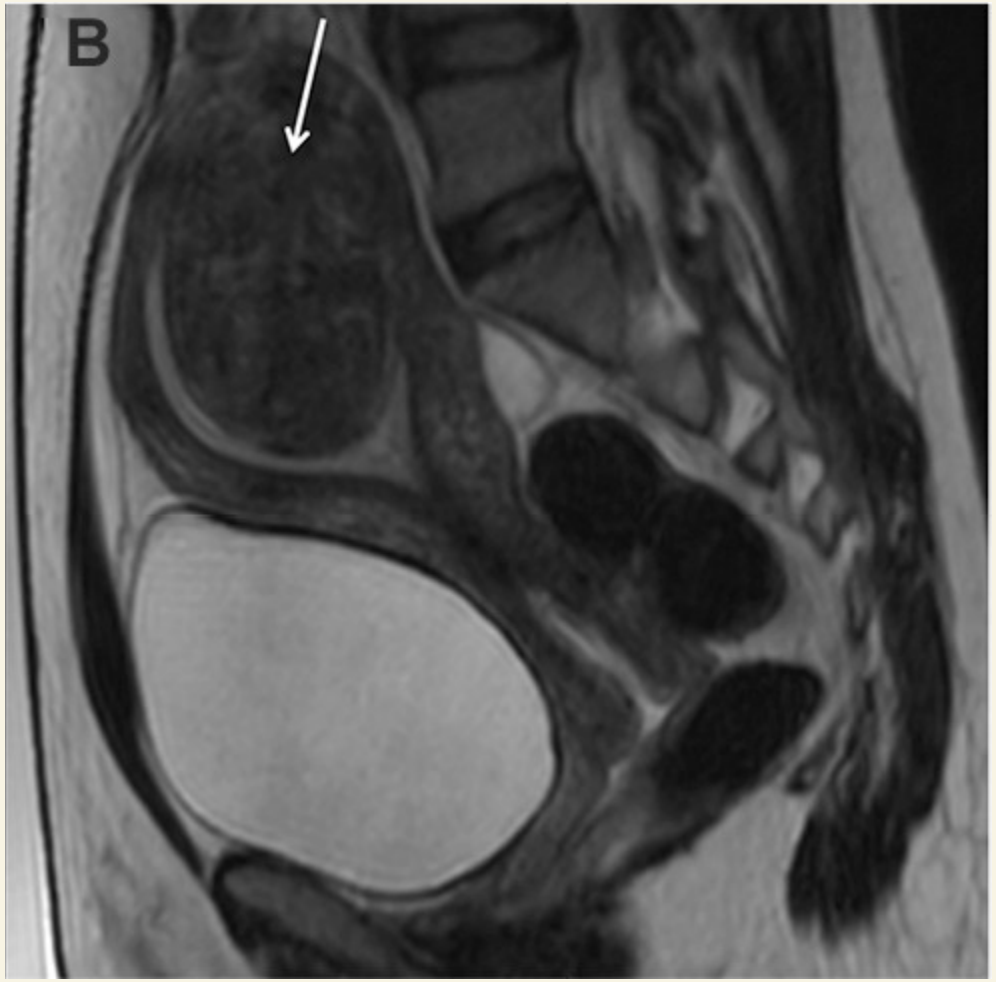

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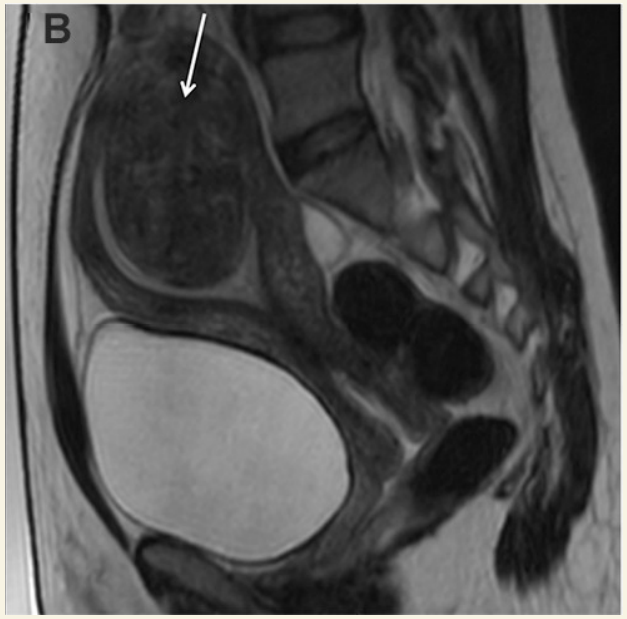
This is an MRI showing a submucosal fibroid projecting into the uterine cavity, we can infer that it is large (look at size of other structures!)

Surgical options for larger fibroids (>3cm) include UAE, myomectomy + hysterectomy



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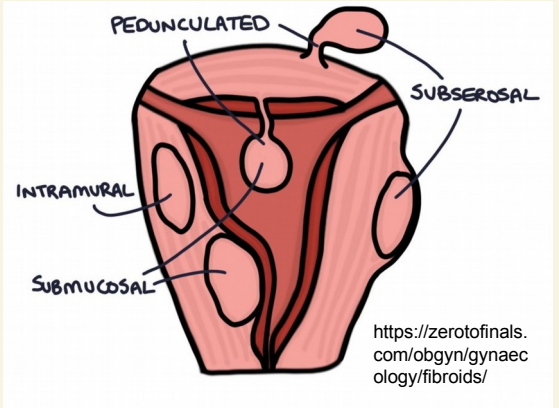


https://zerotofinals.com/obgyn/gynaecology/fibroids/

Menorrhagia - 5 (other) differentials

PERIODS

olpys + PID

ndometriosis + endometrial cancer

eally bad hypothyroidism

ntrauterine contraceptive device

Polycystic _vary syndrome

ysfunctional uterine bleeding

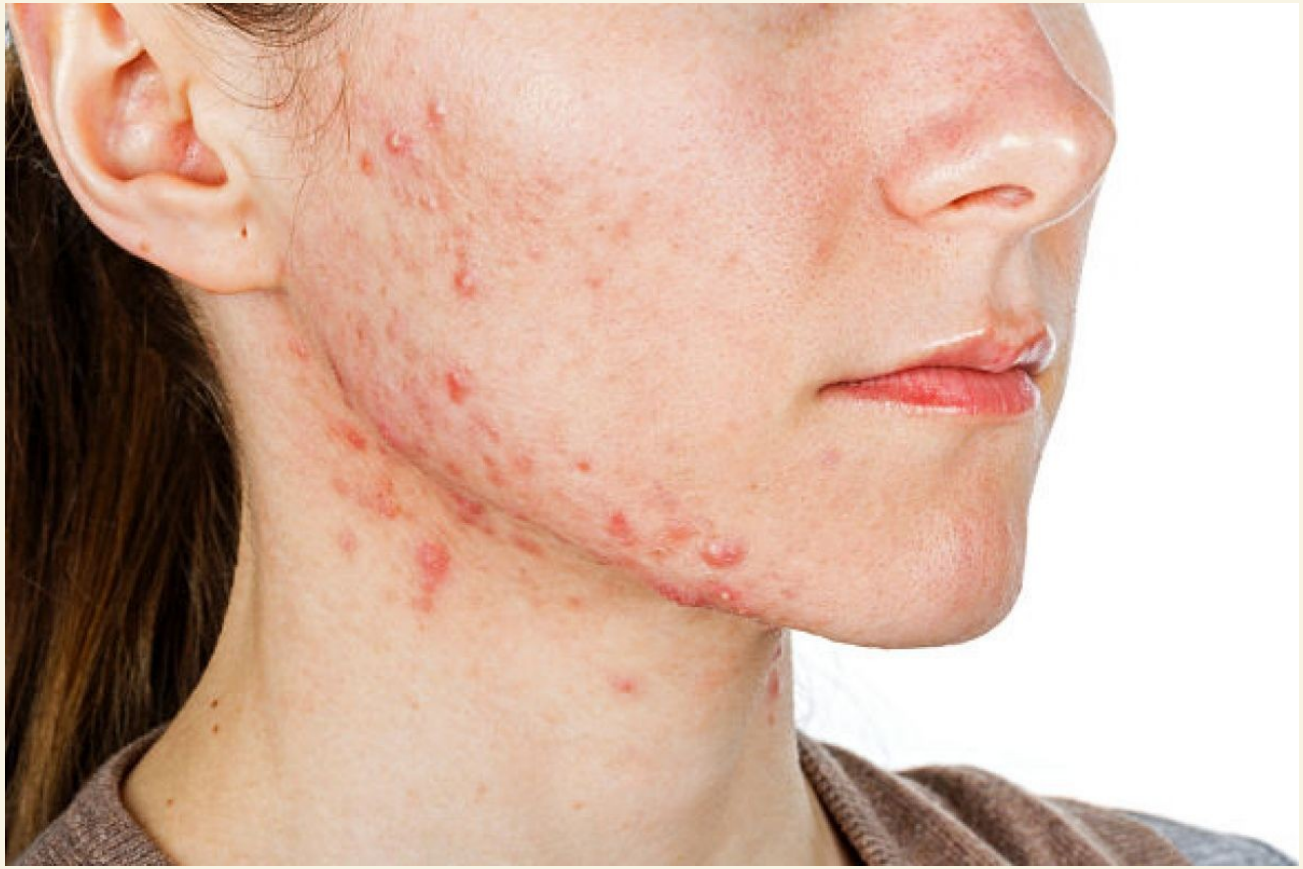
ubmucosal fibroids

Differential diagnosis of menorrhagia	
Diagnosis	**Clinical features**
Endometriosis	• Pain with menses • Dyspareunia • Infertility
Fibroids	• Heavy menses with clots • Constipation, urinary frequency, pelvic pain/heaviness • Enlarged uterus
Adenomyosis	• Dysmenorrhea, pelvic pain • Menorrhagia • Bulky, globular & tender uterus
Endometrial cancer/hyperplasia	• History of obesity, nulliparity, or chronic anovulation • Irregular, intermenstrual, or postmenopausal bleeding • Small, nontender uterus
Endometritis	• Recent instrumentation of the uterus • Foul-smelling discharge • Fever

https://app.pulsenotes.com/specialities/gynaecology/notes/menorrhagia

3: Irregular periods

Katie is an 18 year old who presents to her GP concerned about her periods. In the past 12 months, she has had 7 periods. She takes no regular medication. Furthermore, she is upset as despite a healthy diet and regular exercise, she is struggling to lose weight. She is also unhappy with her skin.



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A. Ovarian volume >10cm3 on USS
B. Male pattern alopecia
C. 10 follicles per ovary on USS
D. Menstrual cycles 40 days apart
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Rotterdam criteria used in the diagnosis of PCOS.
Two of the following three criteria are required:

- oligo/anovulation
- hyperandrogenism
  - clinical (hirsutism or less commonly male pattern alopecia) or
  - biochemical (raised FAI or free testosterone)
- polycystic ovaries on ultrasound

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Polycystic ovaries on USS: 12 or more follicles in one or both ovaries and/or increased ovarian volume >10cm3

Clinical hyperandrogenism: hirsutism / male pattern alopecia
Biochemical hyperandrogenism: raised free androgen index / total or free testosterone

Oligo/anovulation: usually seen in women with cycles >35 days or <21 days

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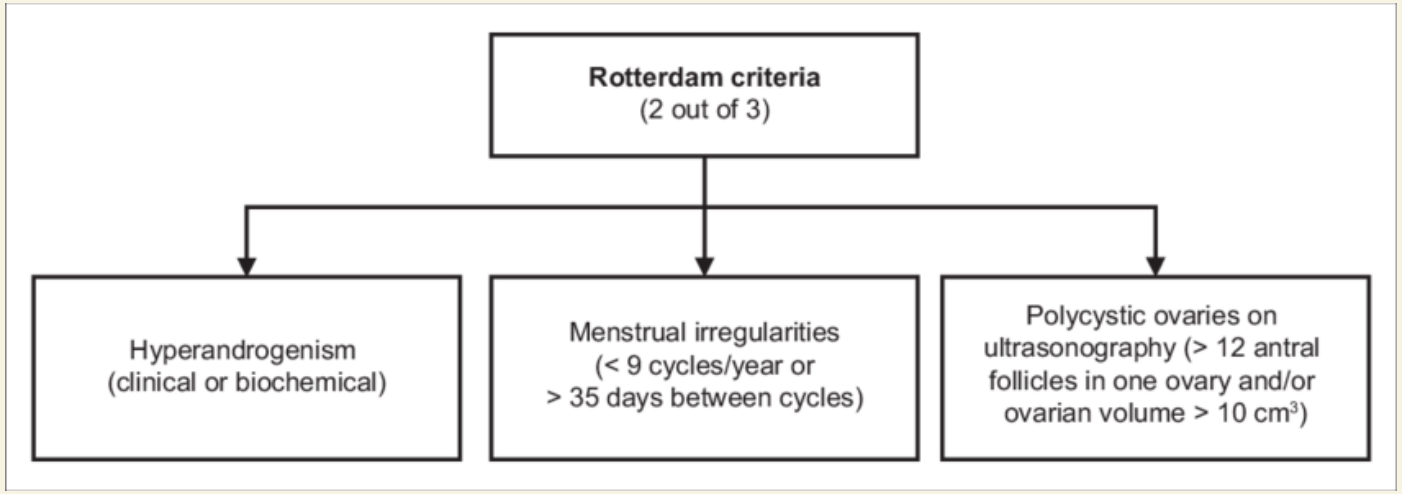


PCOS - 5 (other) key facts

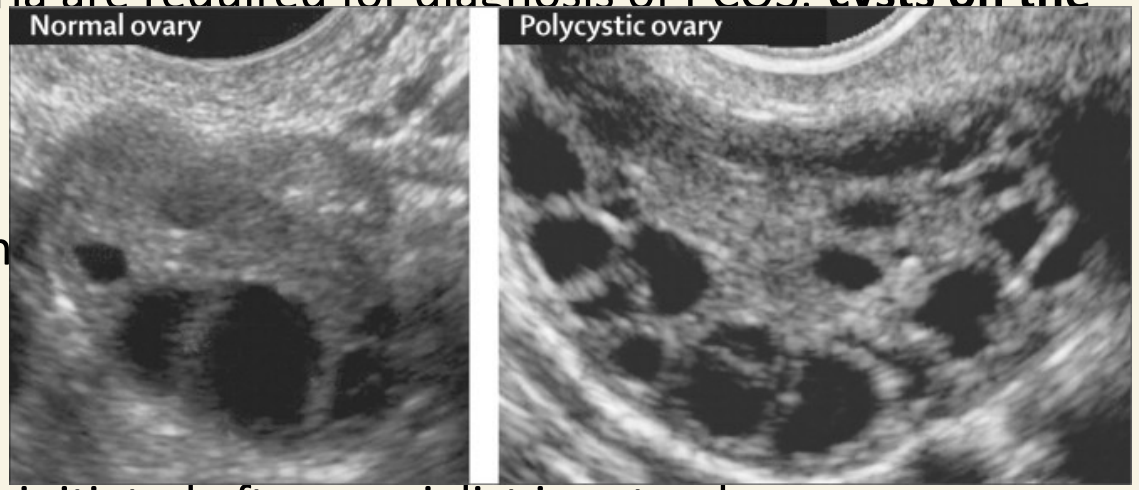
1. May have **raised LH** due to increased production from anterior pituitary

2. **Insulin resistance** occurs --> hyperinsulinaemia, this causes increased androgen production by the ovaries + reduced production of sex hormone-binding globulin (--> raised free testosterone as testosterone is bound to SHBG)

3. Considering only 2 components of the Rotterdam criteria are required for diagnosis of PCOS, **cysts on the ovaries are not necessary for diagnosis of PCOS**

4. It is important to achieve **regular withdrawal bleeds** (at least every 3 or 4 months) to preven hyperplasia

5. **Metformin** can be useful to reduce insulin resistance, initiated after specialist input only



4: Infertility

Mark and Mel attend their GP as they would like to have a baby, but are struggling to conceive.

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Mark and Mel attend their GP as they would like to have a baby, but are struggling to conceive.

1. What is the definition of infertility? (2 marks)
2. What is the difference between primary and secondary infertility? (2 mark)
3. List 2 non-modifiable risk factors for infertility in women (2 marks)

4: Infertility

Mark and Mel attend their GP as they would like to have a baby, but are struggling to conceive.

What is the definition of infertility? (2 marks)

"the failure to achieve a pregnancy after 12 months or more of regular unprotected sexual intercourse"
(WHO,2023)

4: Infertility

Mark and Mel attend their GP as they would like to have a baby, but are struggling to conceive.

What is the difference between primary and secondary infertility? (2 marks)

Primary infertility relates to couples who have never conceived

Secondary infertility relates to couples who have conceived at least once before *(with same or different sexual partner)*

4: Infertility

Mark and Mel attend their GP as they would like to have a baby, but are struggling to conceive.

List 2 non-modifiable risk factors for infertility in women

previous or current STI / obesity / low body weight / smoking / stress / exposure to occupational or environmental hazards / NSAID use / chemotherapy / antidepressant or antipsychotic use / marijuana or cocaine use

4: Infertility

Mark and Mel attend their GP as they would like to have a baby, but are struggling to conceive.

List 2 non-modifiable risk factors for infertility in women

Increasing age / previous or current STI / obesity / low body weight / smoking / stress / exposure to occupational or environmental hazards / NSAID use / chemotherapy / antidepressant or antipsychotic use / marijuana or cocaine use

Increasing age	decreased oocyte numbers, poorer oocyte quality
Stress	affects relationship, libido + frequency of intercourse NSAIDs: can inhibit ovulation
Chemotherapy	can induce (permanent) ovarian failure)
Antidepressants + antipsychotics	can suppress/ affect HPG axis

Risk factors | Background information | Infertility | CKS | NICE

4: Infertility

After trying for a baby with no success for 12 months, Mark and Mel are referred for specialist input and ultimately begin IVF treatment. Shortly after, Mel presents with severe bloating, nausea and vomiting and shortness of breath.

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1. What is the likely diagnosis? (1 mark)

4: Infertility

After trying for a baby with no success for 12 months, Mark and Mel are referred for specialist input and ultimately begin IVF treatment. Shortly after, Mel presents with severe bloating, nausea and vomiting and shortness of breath.

What is the likely diagnosis? (1 mark)

Ovarian Hyperstimulation Syndrome

4: Infertility - extra info

After trying for a baby with no success for 12 months, Mark and Mel are referred for specialist input and ultimately begin IVF treatment. Shortly after, Mel presents with severe bloating, nausea and vomiting and shortness of breath.

What is the pathological basis behind the shortness of breath in this condition?

1. Hyperstimulated ovaries release vasoactive mediators
2. Increased capillary permeability causes fluid shift from intravascular compartment to third space compartments
3. SOB due to pleural effusion

(can have ascites/ pericardial effusions due to effusion in respective cavities)

https://patient.info/doctor/ovarian-hyperstimulation-syndrome

Fertility - 5 (other) key facts

1. **Referral should be considered after 1 year** without conceiving if the woman is **younger than 36 years** with **normal history, examination + investigations** in both partners

2. In women aged **over 36, or if there is a known clinical cause** of infertility or a history of predisposing factors, **earlier referral** is appropriate

3. Initial investigations in both men and women include a **chlamydia test**

4. All women should have a **mid-luteal phase progesterone test** to confirm ovulation (day 21 of a 28 day cycle)

5. Causes of infertility in women can be broken down into **ovulatory disorders** / **tubal damage** / **uterine or peritoneal disorders** / **unexplained cause**

5: Gestational Diabetes

Jane is currently pregnant for the first time. Pre-pregnancy, she was reasonably fit and well, although her BMI was 32 and she has hypertension. She is told she will need testing for gestational diabetes.

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1. When will the screening for gestational diabetes take place? (1 mark)
2. What test is used to screen for gestational diabetes? (1 mark)
3. What levels will indicate gestational diabetes? (2 marks)

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When will the screening for gestational diabetes take place? (1 mark)

24 – 28 weeks gestation

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What test is used to screen for gestational diabetes? (1 mark)

Oral glucose tolerance test

5: Gestational Diabetes

Jane is currently pregnant for the first time. Pre-pregnancy, she was reasonably fit and well, although her BMI was 32 and she has hypertension. She is told she will need testing for gestational diabetes.

What levels indicate gestational diabetes? (2 marks)

Fasting >= 5.6 mmol/L

At 2 hours >= 7.8 mmol/L

5: Gestational Diabetes

At week 26 of pregnancy, Jane has the OGTT. Her fasting glucose level is 6.1 mmol/L.

1. If diet and exercise modification is not adequate in lowering levels, what medical management should be initiated? (1 mark)
2. What is an appropriate target fasting glucose level in gestational diabetes? (1 mark)
3. Name 2 fetal complications of gestational diabetes? (2 marks)

5: Gestational Diabetes

At week 26 of pregnancy, Jane has the OGTT. Her fasting glucose level is 6.1 mmol/L.

If diet and exercise modification is not adequate in lowering levels, what medical management should be initiated? (1 mark)

Metformin

(1-2 week diet and exercise trial, then add metformin then add insulin; if fasting glucose >7 mmol/L on screening OGTT go straight to insulin)

5: Gestational Diabetes

At week 26 of pregnancy, Jane has the OGTT. Her fasting glucose level is 6.1 mmol/L.

What is an appropriate target fasting glucose level in gestational diabetes? (1 mark)

Fasting: 5.3 mmol/l

(NICE 2015:
Fasting: 5.3 mmol/l
1 hour post-meal: 7.8 mmol/l
2 hours post-meal: 6.4 mmol/l
Avoiding levels of 4 mmol/l or below)

5: Gestational Diabetes

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Name 2 fetal complications of gestational diabetes? (2 marks)

1 of: Macrosomia → complications during labour, such as shoulder dystocia, obstructed/delayed labour

And 1 of:

Organomegaly (particularly cardiomegaly)

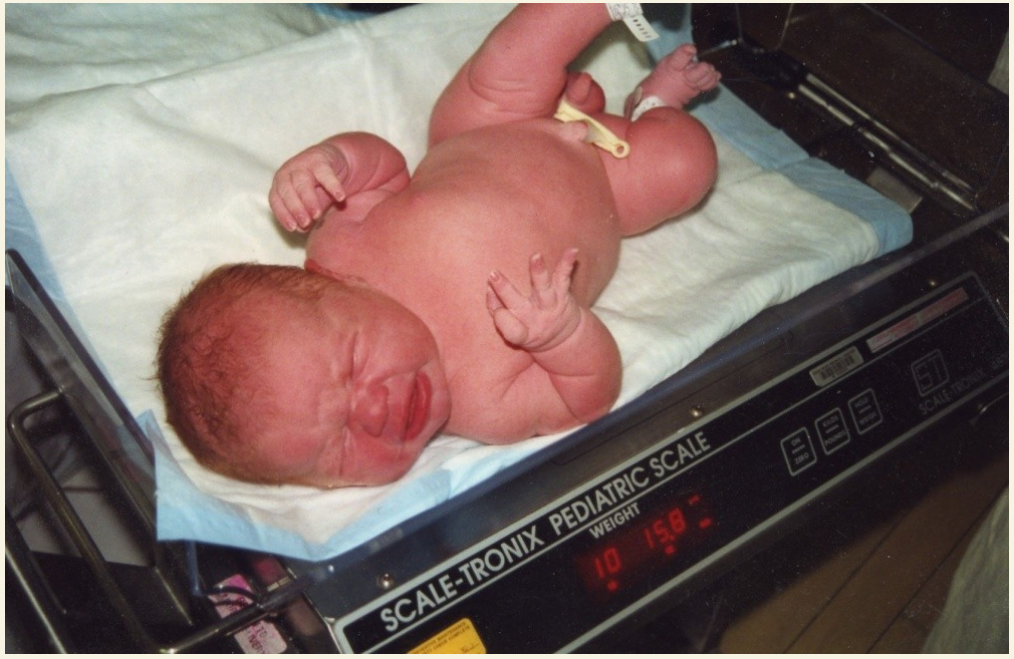
Polycythaemia (due to erythropoiesis)

Polyhydramnios

Increased rates of pre-term delivery

Neonatal hypoglycaemia

Transient tachypnoea of the newborn



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Glucose can be transported across the placenta, but insulin cannot
Maternal hyperglycaemia → fetal hyperglycaemia
→ fetus will increase own insulin levels to compensate → fetal hyperinsulinemia

Insulin has similar structure to growth promoters → macrosomia, erythropoiesis, organomegaly etc

After delivery, fetus still has own high insulin levels but no maternal glucose → hypoglycaemia (hence importance of early, regular feeds!)
High insulin → reduction in pulmonary phospholipids → decreased surfactant production
Decreased surfactant → transient tachypnoea of the newborn

Gestational Diabetes - 5 (other) key facts

1. Women who had **gestational diabetes in previous pregnancies** should have **OGTT at booking**, as well as at 24-28 weeks
2. Women should **monitor their capillary glucose 4x per day**
3. Women with gestational diabetes should have **additional growth scans at 28, 32 and 36 weeks**
4. Women whose gestational diabetes is managed with medication should deliver at **37-38 weeks**
5. All anti-diabetic **medications can be stopped post-delivery** - fasting glucose should be checked 6-13 weeks later

6: Infection in Pregnancy

Which of the following is not true regarding infections in pregnancy?

A. Maternal chlamydia is the most common cause of neonatal conjunctivitis
B. Congenital cataracts are associated with maternal rubella
C. Microcephaly is a feature of congenital CMV
D. Maternal toxoplasmosis is most likely to cause neonatal complications in early pregnancy
E. Maternal parvovirus is most likely to cause neonatal complications in early pregnancy

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Maternal toxoplasmosis is most likely to cause neonatal complications later in pregnancy

Infection in Pregnancy - key facts

Infection	Consequences	Other Key Info
Chlamydia	Neonatal conjunctivitis / neonatal pneumonia / prematurity	Conjunctivitis picked up during vaginal delivery
Rubella	Congenital rubella syndrome ● Congenital deafness ● Congenital cataracts ● Congenital heart disease (PDA and pulmonary stenosis) ● Learning disability	Congenital rubella syndrome caused by maternal infection in first 20 weeks of pregnancy - risk highest before 10 weeks Pregnant women should not be given the MMR vaccination (as it is a live vaccine)
CMV	Congenital CMV ● Fetal growth restriction ● Microcephaly ● Hearing loss ● Vision loss ● Learning disability ● Seizures	CMV can only be passed on during pregnancy when it's 'active': ● Primary CMV infection ● Reactivation of CMV due to weakened immune system ● Reinfection of CMV - diff strain
Toxoplasmosis	Congenital toxoplasmosis - triad 1. Intracranial calcification 2. Hydrocephalus 3. Chorioretinitis (inflammation of the choroid and retina in the eye)	Spread by contamination with faeces from a cat that is a host of the parasite More likely to cause problems later in pregnancy
Parvovirus / B19	Miscarriage or fetal death Severe fetal anaemia Hydrops fetalis (fetal heart failure) Maternal pre-eclampsia-like syndrome	Causes diffuse bright red rash on both cheeks "slapped cheeks" - infectious 7-10 before the rash appears, not infectious once rash has appeared Significant exposure = 15 mins in same room or face to face contact More likely to cause problems in first and second trimesters

7: Vaginal Discharge

Victoria is a 21 year old university student presents with altered vaginal discharge. She has had 8 male sexual partners in the last 6 weeks and barrier contraception has not been used consistently.
She was alerted by one of the partners to attend a sexual health clinic for gonorrhoea testing.

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1. Which laboratory test is used in the diagnosis of gonorrhoea? (1 mark)
2. What medication should she be given at presentation? (2 marks)
3. Name 3 signs / symptoms that would indicate pelvic inflammatory disease (3 marks)
4. If Victoria also presented with stiff, painful, swollen knees and ankles, what diagnosis should be considered? (1 mark)
5. What is disseminated gonococcal infection? (2 marks)

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Nucleic acid amplification testing 'NAAT'

→ look for gonococcal DNA or RNA
tests for gonorrhoea + chlamydia simultaneously

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What medication should she be given at presentation? (2 marks)

Single dose/ stat dose of intramuscular ceftriaxone (1g)

→ if sensitivities are known, other antibiotics may be used, eg oral ciprofloxacin

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3 of:

Symptoms: lower abdominal pain / deep dyspareunia / postcoital bleeding or intermenstrual bleeding or menorrhagia

Signs: lower abdominal tenderness / adnexal tenderness / cervical motion tenderness / fever (>38^{o})

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If Victoria also presented with stiff, painful, swollen knees and ankles, what diagnosis should be considered? (1 mark)

Reactive arthritis

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What is disseminated gonococcal infection? (2 marks)

A complication of untreated gonococcal infection, where the bacteria spreads to the skin and joints

→ skin lesions, polyarthralgia, tenosynovitis, systemic symptoms (fever, fatigue)

Vaginal Discharge Differentials

	———	———	———	———
Description of Discharge	Non-offensive smell, thick/ creamy, white or cream colour	Fishy-smelling, thin, grey/white homogeneous discharge	Increased discharge, yellow or green in colour, 'mucopurulent'	Clear to white, non-offensive smell, consistency + volume changes throughout cycle
Other Symptoms	Vulval or vaginal itch and irritation, superficial dyspareunia, and dysuria.	NOT associated with irritation or itch	Post-coital bleeding, intermenstrual bleeding, dysuria, lower abdominal pain, deep dyspareunia	No other GU symptoms of note
Other Clues In History/ Examination	Very common Increases in pregnancy, use of OCP, uncontrolled diabetes	Use of bubble baths and vaginal products	Recent unprotected sex, multiple sexual partners, new sexual partner, previous STI, younger age	Increased volume in pregnancy, usually decreased volume post-menopause

https://patient.info/doctor/vaginal-discharge#nav-4

Vaginal Discharge Differentials

	Candidiasis	Bacterial Vaginosis	Chlamydia / Gonorrhoea	Physiological
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8: Contraception

Millie is a 17 year old girl who has made a GP appointment to discuss contraception.
She has been in a relationship for a few months with a boy from her college classes and they would like to start having sex. She thinks she would like to try the combined pill.

8: Contraception

Millie is a 17 year old girl who has made a GP appt to discuss contraception. She has been in a relationship for a few months with a boy from her college classes and they would like to start having sex. She thinks she would like to try the combined pill.

Which of the following would not make her ineligible for the COCP?

A. BMI 35
B. Current smoker
C. Hyperthyroidism
D. Migraine with aura
E. BRCA1 carrier

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The other options are UKMEC 3 (risk > benefits, specialist can overrule only) or 4 (unacceptable health risk)
Hyperthyroidism = UKMEC1 for all methods

https://www.fsrh.org/documents/ukmec-2016/

8: Contraception

Millie returns a few months later, distressed because she has forgotten to take 2 pills (last pill taken was 72 hours ago). The first pill she missed was the 16th pill in the current packet. She has never forgotten to take them before. She had sex yesterday.

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B. No action required
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D. Advise condom use for the next 7 days
E. Levonorgestrel

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If 2-7 pills have been missed (72 hours or more since the last pill in the current pack was taken) in week 2 or 3 after HFI

- Emergency contraception is not required if there was consistent, correct use in the previous 7 days
- Avoid sexual intercourse or use a barrier method of contraception until 7 consecutive pills have been taken: (this is overcautious, but is a back-up in case of subsequent incorrect use.)

https://cks.nice.org.uk/topics/contraception-combined-hormonal-methods/management/combined-oral-contraceptive/#missed-coc-pills-except-qlaira-zoely

Conclusion

Opportunity to practice some SAQs + MCQs on a range of O&G and sexual health presentations!

RESOURCES

- Nice CKS summaries
- RCOG guidelines
- Patient Info - Professionals Section
- TeachMeObGyn
- Zero to Finals

https://www.peerteaching.co.uk/phase-3a1.html

Feedback

The Peer Teaching Society is not liable for false or misleading information…


THANK
YOU