



OBG

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CASE 3

- You are at your GP clinic when 26 year old Tess, comes to you with concerns of a right breast lump for past 2 days
- She had a normal vaginal delivery 6 weeks back
- The baby is healthy and had a birth weight of 3.6kg
- **TASKS**
 - 1 Take further history from patient
 - 2 Ask examination findings from examiner
 - 3 Tell her the diagnosis with differentials
 - 4 Discuss management plan with her

CASE 3

DDx of postpartum breast lumps

- **Mastitis**
- **Breast abscess**
- **Blocked milk duct cyst or galactocoele (not painful)**
- **Benign breast conditions**
 - **Fibroadenoma**
 - **Fibrocystic disease**
 - **Breast cyst**
 - **Benign phyllodes tumour (from connective tissue of breast with rapid growth)**
- **Inflammatory breast cancer**

CASE 3

- Congratulations
- Baby doing well
- R/O postpartum blues/ depression

H/O PC

- Single or multiple lumps
- **Skin changes**
- **Mobile**
- **Firm , soft or hard to touch**
- **Getting bigger rapidly**
- Any purulent discharge from nipple
- **Lumps or bumps in axilla**
- **Breast feeding or not**
- **Any sore or cracked nipples (chafing +)**
- **Taught proper breast feeding technique**

Associated symptoms

- **Pain** (discomfort +)
- **Still breast feeding or stopped**
- **Fever** (+)- recorded, chills, rigor, rash, tiredness, muscle aches and pains, medications taken
- **Weight loss**



CASE 3

- **Any previous history of breast lumps or breast pain or generally lumpy breasts**
- **Have you stopped bleeding**
- **Got your periods back, contraception**
- **Any complications during pregnancy or delivery**
- **Tummy pain, abnormal vaginal discharge**
- **Bladder, bowel**
- **Life style- diet, exercise especially pelvic floor exercises, SAD, CST**
- **Other M/S illness**
- **Other medications**
- **Family history of breast lumps or breast cancer**

CASE 3

PEFE

- G/A
- G/E-BMI(22) **pallor, dehydration, lymphadenopathy, rash** (all absent)
- Vitals- **temperature-37.7**
- Respiratory system- normal
- CVS- normal
- Abdomen

Uterus involuted

Tenderness (no)

CASE 3

Breast exam

Inspection

- skin changes (**erythema** in upper outer quadrant of right breast)
- **visible lump** (in upper outer quadrant of right breast)
- **nipple**(no sores or cracks)
- abnormal discharge (absent)

Palpation

- **local rise of temperature** (present over lump)
- **site**(right upper outer quadrant) size (2x 2 cm) **mobility** (mobile)
- **consistency** (firm) **fluctuation** (absent), **tenderness**(+)

Pelvic exam

- Inspection- bleed, abnormal offensive discharge, lacerations (all absent)
- Speculum- cervical lacerations (absent), **os (closed)**
- P/V- **uterine size, tenderness**
adnexa- mass, tenderness

Office tests

- Urine dipstick (normal) BSL (normal)

MASTITIS

Explanation

- **Mastitis is inflammatory process affecting lactating breast caused by infection of the breast by bacteria**
- **Enters breast through cracked nipples from skin of surrounding breast or from baby's mouth**
- **Cracked nipples due to improper latching of baby to breast**
- **Complication is breast abscess when there will be pus collection**

MASTITIS

MANAGEMENT

- **Continue breast feeding from affected breast**
- Place hot packs before feeding, gentle massage
- Place cold packs after feeding
- **Antibiotics- flu or dicloxacillin for 5 days**
- **Analgesics like paracetamol, NSAID**
- Rest, plenty of fluids
- **Proper breast feeding technique**
- Review in 24 to 48 hours
- If not settling- ultrasound to r/o breast abscess, cancers and basic bloods
- Reading material

CASE 5

- Your next patient at your GP is 25 years old Melinda, complaining of a lump in her vulva which has become painful since past 2 days. She is feeling severe discomfort to even sit and walk and wants you to help her.
- TASKS
 - Relevant history from the patient
 - Examination findings from examiner
 - Discuss your diagnosis with the patient
 - Explain your management plan to the patient

CASE 5

DIFFERENTIALS

- Bartholin's abscess
- Infected Sebaceous cyst
- Infected Mucous cyst
- Infected Lipoma
- Bartholin's cyst
- Bartholin's benign tumour- adenomas
- Skene's duct cyst- periurethral or paraurethral



CASE 5

Concerns

Pain score, offer pain killer

Pain Q's

History of lump

- Duration, single or multiple, increasing in size or not, skin changes, any rash or vesicles, discharge, first episode
- Fever, chills, rigor, muscle aches, tiredness, lumps or bumps in the body especially around groin
- Abnormal vaginal discharge or bleed

Periods

- LMP, regularity, concerns

Sexual history

stable partner, STI's, contraception, pregnancies, CST

- Bladder
- Bowel

CASE 5

- Any other M/S illness
- Medications, allergies
- SAD



CASE 5

Examination

- G/E- BMI (22) **inguinal tender lymphadenopathy** (absent)
- V/S- **Temperature** (37.9)
- CVS/ Resp - normal
- Abdomen- soft, non tender
- Pelvic examination
- Inspection
- **Site, colour, skin changes**
- Visible lump, seen as reddish yellow swelling at 8' o clock position at the lower part of right labia minora
- Size(2x3cm), no discharge or bleed, rash or vesicles
- No abnormal vaginal discharge/ bleed
- **Palpation- local rise of temperature**(present)
- **consistency** (cystic), **fluctuation** (present)
- Office test- **UPT**, Urine dipstick, BSL (normal)

BARTHOLIN'S ABSCESS

Explanation

- Bartholin's glands are glands present on either sides of vaginal opening
- Secretes mucous and lubricates vagina
- Ducts of glands get obstructed leading to collection of secretions inside the gland- Bartholin's cyst
- **This gets infected with bacteria forming pus collection leading to formation of abscess- Bartholin's abscess**
- (Organism- E.coli, staph
Gonococci, Chlamydia)

BARTHOLIN'S ABSCESS

Bartholin's abscess

Treatment

- Referral to hospital
- Will arrange investigations- all basic bloods including sugar levels, STI screen
- Incision and drainage under anaesthesia with insertion of Word catheter which is removed 4 weeks later or packing which is removed the next day
- Pus for C&S
- Adequate pain killers
- Antibiotics
- Sitz bath
- Advice safe sex
- Good genital hygiene
- Marsupialisation- if recurrent
- Gland incised, cleaned out, then cut edges of gland is stitched into sides of labial wall so that gland remains open which forms a permanent pocket for continuous drainage and prevents recurrence

CASE 6

- 13 week pregnant lady, Jane 26 years ,comes to your GP complaining of tiredness. She had seen another GP for this who had advised some blood tests for her. She is here for results today as the previous GP who ordered the tests is not available
- Blood Results shows
- Hb: low
- MCV: low
- MCHC: low
- TASKS
- 1 Take history and discuss results (5 mts)
- 2 Tell her your diagnosis/ DDx
- 3 Discuss with her what other investigations will you order

CASE 6

DDx

- **Iron deficiency anaemia**
- **Thalassemia**
- **Chronic illnesses**



CASE 6

HISTORY

- **Concerns**
- **Tiredness H-** duration, all throughout or towards the end of the day
- **Associated symptoms-** palpitations, SOB, dizziness, chest pain
- **Iron deficiency Q's**
- 1st pregnancy (yes) (otherwise spacing)
- Any miscarriages
- Diet (no specific diet, vegetarian/ non vegetarian)
- Period history- menorrhagia
- Bleeding from any other parts of body
- **Thalassemia Q's**
- **Ethnicity of her and partner(patient Italian, husband Vietnamese)**
- **Symptoms in partner**
- **Family h/o anaemia or other blood disorders (unaware)**
- **Any other chronic illnesses (no)**
- **SADMA (no)**

CASE 6

A/N H

- Current state of pregnancy- tummy pain, vaginal bleed or abnormal discharge
- Planned pregnancy
- Symptoms of pregnancy
- Taking folic acid/ pregnancy supplements (yes)
- Blood group
- Dating scan
- Down's screen

Support

CASE 6

- Explain microcytic, hypochromic anaemia
- Blood has 3 types of cells- Red, white and platelets
- RBC's carry an iron rich protein called HB that carries oxygen to different parts of your body
- The results show low HB and the size of RBC's are also reduced, content of Hb in each red cell is also reduced and this blood picture is called microcytic, hypochromic anaemia

CASE 6

- There are several causes for this kind of blood picture among **which iron deficiency is the commonest which happens if your diet is deficient in iron, decreased iron absorption from diet, if you had heavy bleeding during your periods before pregnancy, miscarriages, closely spaced pregnancies and also if you have bleeding from any other part of your body But you have no history of any of these**
- Next is **thalassemia minor which are a group of inherited blood disorders where there is defective production of HB as it affects the ability to make healthy HB found in people from Mediterranean countries like Italy where you are from So this can be the reason in you**
- Happens when certain genes become permanently mutated and this is a life long condition
- And this might not produce any symptoms unless severe
- There could be increased destruction of this abnormal HB and as pregnancy increases the demand on red cell production it causes anaemia and thereby tiredness
- **Complications**
 - **In mom- anaemia during latter half of pregnancy**
 - **In baby- getting thalassemia as it runs in families, IUGR**
- Another cause is **chronic illnesses which you do not have**

CASE 6

OTHER INVESTIGATIONS

- **Hb electrophoresis and genetic testing for thalassemia**
- **Better to get her partner tested for thalassemia**
- **Iron studies** (serum iron, ferritin or iron stores, transferrin or total iron binding capacity)

CASE 7

- Your next patient at your GP is 28 year old Monica who was diagnosed with SLE 3 years back
- She is planning for a pregnancy now and is seeking your advice regarding her future pregnancy
- **TASKS**
 - 1 Take further history from patient
 - 2 Explain to her the complications she can have during pregnancy
 - 3 Discuss the investigations that you would like to arrange for her now

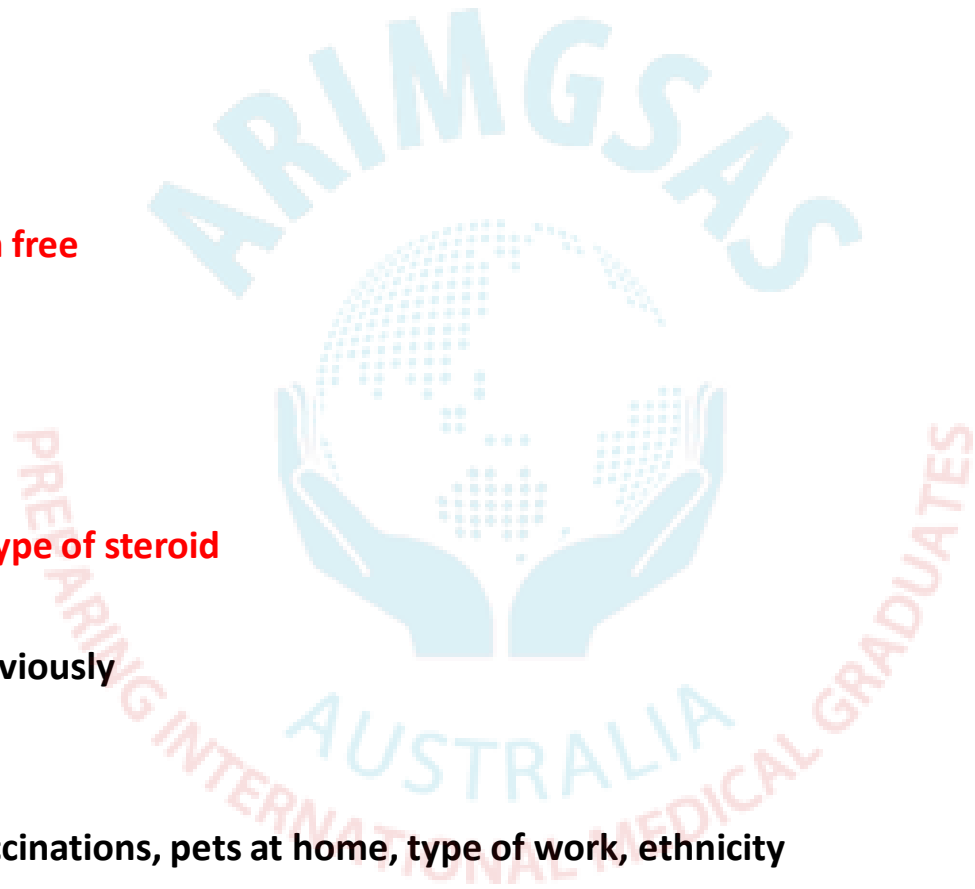
CASE 7

HISTORY

- When planning for pregnancy
- First pregnancy
- **Any miscarriages**

Regarding SLE

- **How long she has been symptom free**
- Any rash, joint pain now
- **Any kidney complications**
- Hospitalisations
- Last visit to specialist
- **Medication she is currently on- type of steroid**
- Dose, compliance, side effects
- Any other medications taken previously
- Period history
- Sexual history
- Life style- SAD, diet, exercise, vaccinations, pets at home, type of work, ethnicity
- Awareness of her fertile period
- Other M/S illness, allergies
- Support
- Family H of birth defects, miscarriages



CASE 7

Complications

- Fertility not affected by SLE unless patient had taken cytotoxic medications
- Pregnancy can cause flare up of SLE but if well controlled for 6 months or more, chance of flare up is rare and even if flare up happens it will be mild

Complications during pregnancy

- In mom
 - Miscarriage, hypertensive disorders of pregnancy, preterm labour**
 - Post partum- SLE can flare up
- In baby
 - IUGR, heart block, prematurity**
- After birth baby can have **neonatal lupus syndrome**
- **not SLE in baby, but baby can have unusual blood counts and rash which clears off in 3-4 months time**

SLE

Investigations to be done in preconception phase

- FBE
- ESR/CRP
- **RFT with GFR**
- LFT
- TFT
- FBS
- Blood group Rh
- Coagulation profile
- STI screen
- Antibodies for rubella, varicella
- Vitamin D
- **Anti cardiolipin antibodies**
- **Lupus anticoagulant**
- **Anti DS DNA**
- **Thrombophilia screen**
- Urine routine



CASE 10

- You are at your GP, when 30 year old Amanda, who is 9 weeks pregnant comes to collect the results of her first visit blood test, she had done 2 weeks back with another GP. She has come to you as her usual GP is not available today
- The blood test results are as follows
- FBE, UCE FBS, LFT, TFT, Vitamin D- Normal
- Beta HCG- positive
- Blood group- A +ve
- IgG antibodies for rubella and varicella – positive
- HbsAg- negative
- HCV antibody- negative
- VDRL – negative
- HIV – positive
- Urine tests- normal
- Dating scan result- pending
- TASKS
 - 1 Take further history from patient
 - 2 Discuss the blood test results with her
 - 3 Explain to her further management

CASE 10

HISTORY

- First pregnancy
- **Planned pregnancy**
- Confidentiality
- Current state of her pregnancy
 - Tummy pain, bleed, abnormal discharge, morning sickness, pregnancy supplements, information about Down's screen
- Period history- **LMP**
- **Sexual history**
 - Stable partner, how long, multiple partners before**
 - Contraception used before pregnancy**
 - STI screening**
 - Miscarriages**
 - Cervical cancer screen
- **SAD**
 - IV drug abuse, sharing of needles, stopped taking it or not**
 - Any blood or blood products received, body piercing, tattooing**
- **Symptoms of AIDS**
 - unexplained fever, weight loss, recurrent infections, lumps/ bumps in body**
- Bladder/bowel
- Other M/S illness, medications, allergies

CASE 10

DISCUSSION OF RESULTS

- Start with good results
- Make her aware of her blood group
- **Breaking bad news regarding HIV positivity**
- **Ask if she had been made aware regarding HIV testing and implications if it becomes positive**
- Check her awareness regarding HIV
- Otherwise explain what HIV is
- HIV is a virus that cause the disease AIDS transmitted through sexual intercourse, sharing of needles with infected persons, receiving blood or blood products of infected people
- AIDS developed person cannot fight off diseases as an uninfected person will and carries risk of developing certain cancers and other health problems
- A person with HIV positivity might not develop AIDS for a long time
- Tell her unfortunately she is HIV positive
- Offer her support
- **Make her aware of the risk of transmission to the baby during pregnancy, labour and through breast feeding**

HIV IN PREGNANCY

MANAGEMENT PLAN

From GP

- **Reportable disease**
- **Contact tracing**
- **Ensure confidentiality**
- **Encourage partner to get tested for STI**
- **Offer support in disclosing to partner if she wishes**
- **Use of condoms during intercourse**
- **Referral to high risk pregnancy clinic**

HIV IN PREGNANCY

At high risk clinic

- MDT approach with obstetrician, HIV specialist, paediatrician, psychologist, social worker
- HIV physician may advise further blood tests like HIV viral load, CD4 cell count, HIV resistance testing
- **Start on antiretroviral medications which needs to be taken all throughout pregnancy, delivery and post delivery**
- Need to be compliant with medications as the risk of transmission to baby is reduced to 2-5%
- More frequent A/N checks, blood tests and scans along with routine tests of pregnancy
- Counselling services for both her and partner

HIV IN PREGNANCY

Delivery

- **Mode of delivery depends on HIV viral load. If low, obstetrician will plan for vaginal delivery**
- **Otherwise C- section**

Post partum

- **No breast feeding**
- **Baby will be checked by paediatrician**
- **Antiretroviral therapy to baby for first 6 weeks and then will be decided if needs to continue**
- **Antiretroviral therapy will be continued for you**
- **Reading materials**

CASE 11

- Olivia, 32 years who is 35 weeks pregnant, comes to your GP complaining of an itch. She appears pretty concerned about this
- TASKS
 - 1 Take history from patient
 - 2 Discuss diagnosis with the patient
 - 3 Explain your further management plan to the patient

CASE 11

DDx

1 PUPPP

2 Cholestatic jaundice of pregnancy

3 HELLP syndrome

4 Atopic dermatitis of pregnancy

5 Contact dermatitis

6 Allergies

7 Pemphigoid gestationis

8 Skin conditions like eczema, psoriasis



CASE 11

- Intro
- **Site of itch** (belly)
- Duration (1 week)
- Itching at any other parts like thighs/ buttocks/ vagina (no)
- Worsening (yes)
- **Any rash** (yes)
- **Where did the rash start from (on and near stretch marks)**
- **Any fluid filled pockets, open sores (no)**
- **Any discharge/ bleed (no)**
- **Any fever, pain, lumps or bumps (no)**
- **First episode (yes)**

CASE 11

- Any yellowish discolouration of skin/ eyes or urine
- Any headache, vision problems, oedema
- Any change in the material of your clothing (no)
- Any new body wash or creams or lotions applied over your belly (no)
- Any personal or family history of eczema, asthma or hay fever (no)

A/N H

- First pregnancy
- Regular checks, last check, concerns
- Blood test / blood group
- Scan at 20 weeks- single baby, concerns
- Sugar test at 28 weeks
- Baby kicking well

CASE 11

- **Other M/S conditions, medications, allergies**
- **SAD**
- **Support**



CASE 11



CASE 11

DIAGNOSIS

- **Polymorphic eruption of pregnancy** (PUPPP- pruritic urticarial papules and plaques of pregnancy)
- **A very itchy and bumpy rash that affects pregnant women especially in the third trimester**
- **Starts in the stretch marks**
- **More common in first pregnancy and if there is excessive weight gain during pregnancy like in multiple pregnancies and if you have male baby**

Cause

- **rapid stretching of skin causes connective tissue damage** making it vulnerable for inflammation the reason why it happens in late weeks of pregnancy and also if you have multiple babies
- has also been said to be an **allergy like reaction to foetal cells in mom's blood**

PUPPP

- **A PUPPP rash is not dangerous to you or your baby but itching can be awful**
- **Rash clears within 4 to 6 weeks of delivery**
- **Rarely causes eruption in baby after birth but soon fades**
- **No worrisome short term or long term consequences or recurrence in future pregnancies**

PUPPP

MANAGEMENT

- No curative treatment as such but itching can be well controlled
- Arrange investigations- FBE, CRP, UCE, **LFT** and urine routine
- **Moisturisers like aloe vera gel**
- Cool, wet compresses
- Bath with oatmeal or baking soda
- Wear loose, cotton clothing
- **Topical steroids thinly once or twice daily**
- **Antihistamines like chlorpheniramine**
- **If not working, short course of oral steroids like prednisolone**
- Review in 1 week time
- Continue routine AN care with bug test at 36 weeks and also monitor baby kicks
- Reading materials

CASE 16

- 56 year old Jenny is your next patient at your GP
- She is on HRT for the last 6 years. She is not having any menopausal symptoms now. She has come to you for a repeat HRT script
- She is not up to date with her mammogram and HPV screen
- TASKS
 - 1 Take history from Jenny
 - 2 Counsel patient accordingly
 - 3 Discuss further investigations that you will arrange for her with her

CASE 16

Concerns

- Reason for repeat script
- Reason for starting HRT
- Any menopausal symptoms now
- Regular/ last follow up
- Any risks of HRT so far- pain in calf muscles, stroke, chest pain, palpitations, high BP, cancers
- Contraindications for HRT- active liver disease
- Menopausal H- age, post menopausal bleed

Sexual H

- dyspareunia, post coital bleed, children

CASE 16

- Reason for not being up to date with mammo / CST
- Bowel cancer screen done or not
- Last screen
- Any abnormal results
- Any self breast examination that she does
- Any breast lumps, nipple discharge
- Weight loss, lumps or bumps around the body
- Bladder- incontinence
- Other M/S conditions, medications, allergies
- Life style- diet, exercise, SAD
- Family h/o cancers

CASE 16

COUNSELLING

- Ask her if she knows about HRT

RISKS WITH LONG TERM HRT

- Risks of long term HRT that is if taken more than 5 years can outweigh the benefits of HRT
- The risks can be getting increased chance of heart disease, stroke, blood clots
- Can increase risk of breast cancer
- Consider stopping HRT
- Will gradually taper by lowering dosage over 3 to 6 months and then stop
- Meanwhile LSM
- If symptoms reappear which is unlikely, refer to specialist who might consider restarting her on low dose HRT or give her alternatives to HRT
- Is debatable if HRT can be continued after 5 years

LONG TERM HRT

MANAGEMENT

Arrange investigations

- Bloods- FBE, CRP, UCE, LFT, TFT, FBS, S. lipid profile, Vit D
- Urine routine
- CST with her consent. Explain need for CST
- To be repeated every 5 years if results are normal
- Mammogram now as there is high risk of breast cancer with HRT. Explain. Need to be repeated every 2 years
- Bowel cancer screen . Need to be repeated every 2 years
- Review with results
- Reading materials

CASE 17

- 50 year old Ann is your next patient at your GP clinic. She has hot flashes and irregular periods for the last 6 months
- Her physical examination is all normal
- Basic blood investigations (FBE,CRP, UCE, LFT, FBS) done are also normal
- TASKS
 - 1 Take further history from Ann
 - 2 Discuss with her the condition and your management plan
 - 3 Explain the risks and benefits of your management plan

CASE 17

DDX

- Perimenopause
- Thyroid disturbances
- Hyperprolactinemia
- Hypoglycemia
- Pheochromocytoma
- Carcinoid syndrome
- GAD



CASE 17

Concerns

Other symptoms

- Sweating, mood swings, sleep disturbances, vague muscle pains, bone pain
- Vaginal dryness, soreness
- Dysuria

Period history

- LMP, how often, number of days of bleed, heavy or light bleed, intermenstrual bleed, clots, pain

Period history before 6 months- regularity, number of bleeding days, severity

Affecting ADL

Sexual history

- Stable partner, dyspareunia, post coital bleed, contraception (partner had vasectomy) STI, children, CST screen, mammogram, bowel cancer

CASE 17

DDX

- Weather preference, bowel habits
- Milky breast discharge
- Taking regular meals, DM
- Frequent headaches, postural dizziness
- Diarrhoea, any facial skin lesions
- Generally anxious person

Contraindications for HRT

- DVT
- Recurrent angina, recent MI, uncontrolled HT
- Stroke
- Active liver disease
- Endometrial/ breast/ ovarian cancer –
- Any weight loss/ lumps around body

Life style

- Diet, exercise, SAD
- Other M/S illness, medications, allergies
- Family h/o genital cancers or breast cancer



PERIMENOPAUSAL HRT

- The reason behind the hot flashes and sleep disturbances can be because you are going in for menopause and due to a reduction in oestrogen the female hormone as ovaries start shutting down
- **Can benefit by starting HRT**
- **(OCP if she requires contraception and if below 50 years)**
- HRT has combination of hormones oestrogen and progesterone which replaces the lost oestrogen. Progesterone is added to reduce uterine lining thickening caused by oestrogen alone
- **Need to do further tests like TFT especially as thyroid disturbances can also cause similar symptoms, FSH and LH and arrange for mammogram**
- **Trans vaginal U/S**
- **Also UPT as LMP delayed**
- **Will be started on cyclical HRT and then you will get cyclical bleeds rather than irregular periods**
- S/E- nausea, bloating, headaches, breast soreness, break through bleed
- LSM- cut down on spicy foods, limit coffee, alcohol within safe limits
- Follow up in 6 to 8 weeks and then 6 monthly and then annually
- Be up to date with cancer screens

PERIMENOPAUSAL HRT

Benefits of HRT

- Alleviates all perimenopausal symptoms
- Sleep improves
- Prevents osteoporosis
- Prevents bowel cancer

Risks

- DVT
- Stroke
- Breast cancer
- Endometrial cancer
- Gall bladder disease

Reading materials

Review with results



CASE 18

- 22 years old Grace is your next patient at your GP. She complains of having spotting and bleeding in between periods for past few months which she is concerned about
- TASKS
 - 1 Take further history from Grace
 - 2 Ask examination findings from examiner
 - 3 Discuss her diagnosis with her

CASE 18

DDx for intermenstrual bleed

- Mid cycle bleeding with ovulation
- Hormonal contraception
 - Breakthrough bleed with OCP
 - Depo MPA
 - IUCD
- Cervical ectropion
- STI- cervicitis, PID
- Endometrial/ cervical polyps
- Fibroids
- Endometriosis
- PCOS
- Ovarian cysts/ tumours
- Cancer endometrium, Cancer cervix
- Bleeding disorders
- Blood thinning agents



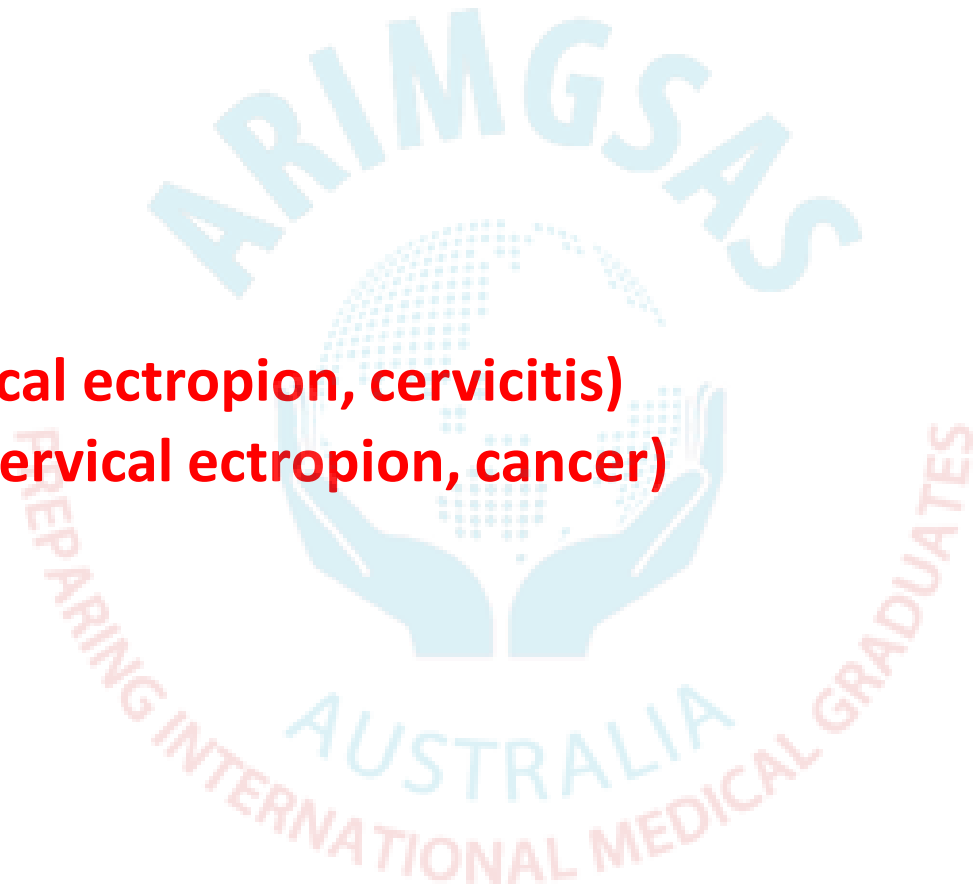
CASE 18

- Intro
- Confidentiality
- Concerns
- Bleeding at the moment
- H/O bleed
 - Colour, smelly, severity, worsening
- Associated symptoms
 - Tummy pain (ovulation pain), Tiredness, dizziness
- blood group
- Period History
 - LMP, regularity, days of bleed, mild or heavy, clots, pain, intermenstrual pain (endometriosis)

IMB

Sexual History

- Sexually active
- Stable relationship
- **Dyspareunia (cervical ectropion, cervicitis)**
- **Post coital bleed (cervical ectropion, cancer)**
- **STI**
- **Contraception**
 - Type (on OCP)
 - Duration (2 years)
- **Compliance**
- HPV vaccine



IMB

DDx Q's

- Does the bleed happen around 14 days of your cycle
- Any other abnormal vaginal discharge(STI, ectropion, cancer cervix)
- Any feeling of something bulging into vagina (polyp)
- Any pelvic heaviness (fibroids)
- Defaecation pain (endometriosis)
- Weight gain, acne, hirsutism (PCOS)
- Weight loss, lumps/ bumps (cancers)
- Other M/S illness like bleeding disorders
- Medications like blood thinners
- SAD
- Family h/o of cancers

IMB

PEFE

- G/A
- G/E
- **BMI(20), pallor, acne, hirsutism, lymphadenopathy (Nil)**
- Vitals
- Temperature, BP (normal)
- CVS/ Respi (normal)
- Abdomen
 - Mass, tenderness (soft, non tender)**

IMB

Pelvic exam

- Inspection of V&V
- **Bleed, abnormal vaginal discharge**, rash (No)
- Speculum
- **Cervix- healthy (red ring around os present)**
- **bleed, abnormal discharge (No)**
- **Vaginal walls- healthy**
- P/V
- CMT- negative
- **Uterus- size (normal) tenderness (No)**
- **Adnexa- mass**, tenderness (No)

Office tests

- **UPT**(negative), dipstick, BSL (normal)

IMB

DIAGNOSIS

- **Cervical ectropion**
- Due to migration of endo cervical cells into ecto cervix
- Cause- under oestrogenic influence . **OCP can be the causative factor**
- **Can cause IMB and spotting**, dyspareunia, post coital bleed, abnormal mucosal discharge and is **seen as red ring around cervical opening**



CASE 19

- 24 year old Mary, presents to you at your GP with complaints of Right lower abdominal pain for the last 1 hour. You ordered a pelvic and abdominal ultrasound which showed a ruptured ovarian follicle, free fluid in POD, appendix not visualised and gall bladder with 3 stones, each of 1.5 mm and gall bladder wall thickness to be normal. Her last menstrual period was 2 weeks back

She had appendicectomy at the age of 12

- TASKS
- 1 Explain ultrasound results to Mary
- 2 Discuss with her the most probable diagnosis
- 3 Explain to her further management

CASE 19

Explanation of USG findings

- Ovaries are a part of female reproductive tract
- During each period cycle, several follicles develop in your ovaries out of which one matures which then breaks open to release the egg or ovum. This happens approximately around 14 days of your cycle
- If you undergo unprotected sex during this time the ovum will get fertilised resulting in pregnancy
- The scan shows that there is a follicle that has broke open to release the egg

CASE 19

EXPLANATION OF USG

- There is a small pouch called POD between your womb and back passage
- Scan shows some fluid in this pouch which happens due to various causes and ovulation is one of the reasons as some fluid released during this time due to rupture of follicle can collect in this pouch
- Appendix is a small finger like tube attached to your large bowel on the lower right side of your tummy
- This is not visualised as you had your appendix taken out before

CASE 19

- The gall bladder is a small sac that holds bile, a digestive juice secreted by your liver that is used to break down dietary fats
- Scan shows 3 small stones of 1.5mm in your gall bladder which are formed from fats, calcium salts and bile pigments
- But the wall of GB is not showing any signs of infection or inflammation as the wall thickness is normal

MITTELSCHMERZ

PROBABLE DIAGNOSIS

- **The most probable reason behind the tummy pain that you have is ovulation pain or midcycle pain due to the rupture of the mature follicle**
- **During this time along with the egg, some fluid and blood will be discharged into your tummy cavity which causes irritation of the tummy lining called peritonium and a local inflammation happens. There will also be some associated spasm of the tubes attached to your womb. All these results in pain.**

MITTELSCHMERZ

FURTHER MANAGEMENT

- Ovulation pain is a self limiting condition
- Settles by its own
- Nothing to be alarmed
- Rest
- Take pain killers like panadol/ panadeine
- Can place hot packs over the area
- Warning signs
 - Excessive pain/ heavy vaginal bleed please report
- If recurrent and disabling, OCP can help
- Regarding gall stones, there is no need to worry as you are not having any symptoms
- But just in case you develop any upper tummy pain, fever, vomiting do report to the hospital to be seen by specialist
- Reading materials

POD FLUID

DD of FLUID IN POD

- **Ovulation**
- **Ruptured ovarian cyst**
- **PID**
- **Ruptured ectopic**
- **Retrograde menstrual flow**
- **Appendicitis**
- **Ascites due to cardiac failure/ liver failure/ cancer**

CASE 20

- 65 year old Olivia is your next patient at your GP, complaining of bloating of her tummy for around 6 months. She also has prolonged history of constipation, loss of appetite and significant weight loss. She has no history of shortness of breath or jaundice. She is a nulliparous woman and her BMI is 28 at present She is up to date with all cancer screens
- She has a strong family history of bowel cancer in her father and brother and cancer breast in her sister and all are doing well now
- Pelvic examination showed right adnexal fullness
- You had ordered a transvaginal ultrasound which showed a 12 cm right ovarian mass with solid and cystic areas with papillary excrescences. A doppler ultrasound done showed increased vascularity
- TASKS
- Correlate examination and ultrasound findings and explain to patient the probable diagnosis

CASE 20

- Intro
- How you are feeling at the moment
- Symptoms still the same
- As you know you have been feeling tummy problems like abdominal fullness, bloating, change in bowel habits and whole body symptoms like loss of appetite with unexplained weight loss which are non specific
- Draw picture of uterus, tubes and ovaries
- On internal vaginal examination, I could feel a fullness and lump in your right ovary
- The imaging ultrasound shows a 12 cm tumour in your right ovary which shows both solid and cystic or fluid filled areas with finger like solid projections from the ovarian lining and this tumour is showing increased blood flow

OVARIAN CANCER

- All these when put together with other risk factors like advanced age, overweight, no pregnancies and a strong family history of breast and bowel cancer, the next news that I have got for you is not good and I am sorry to tell you that all these strongly suggest cancer in your right ovary
- I can imagine your emotions at the moment. Anybody with you today Do you need someone to be with you at this time. Do you need me to call someone in who can be with you
- Do you have enough support from your family or friends
- Sorry this has been quite a distressing situation for you
- Good that you do not have SOB or jaundice. So unlikely of spread to your lungs or liver
- To ensure that you receive the best possible care, I will arrange a team of health professionals, a multi disciplinary team, based on your preferences and needs. I will arrange for other investigations like tumour markers and referrals to specialists to confirm the diagnosis
- Once confirmed, to find out more about the best ovarian cancer care that you will be provided at each step of your journey, you can call Ovarian Cancer, Australia or qualified cancer nurses at Cancer Council to answer your questions about effects of cancer, what will happen during treatment and they will link you to support groups and other community services
- I will provide you print outs of their contact details and also regarding ovarian cancer
- Do understand that you are not alone in this journey. We will all be there supporting you as a team in each step

CASE 20

MANAGEMENT

- Staging to look if confined to ovary or has spread to other pelvic organs or tummy lining with or without fluid. So need to do further blood tests (CA 125), CT, MRI, PET scans

Further treatment will depend on staging which can be

- Surgery to remove uterus, both tubes and ovaries, or debulking surgery if spread to other organs
- Chemo therapy to destroy remaining cancer cells by injecting 1 or 2 drugs through vein
- Radiotherapy to treat cancer cells which had spread into pelvis or to other sites
- Palliative care

PAPILLARY EXCRESCENCES

