Gynaecology Emergencies

- 1. ‘ Gynaecology Emergencies’ Dr. Harris N S Consultant & Head of O&G Dept. Sarawak General Hospital
- 2. ‘ Gynaecology Emergencies’ Ectopic pregnancy Miscarriage Hyperemesis gravidarum Cervical incompetence Severe pelvic pain Massive ‘menstrual’ blood loss ‘ Emergency’ contraception
- 3. ‘ Ectopic Pregnancy’
- 4. Ectopic Pregnancy Rising incidence ~ 1% of all pregnancies 95% located in fallopian tubes Delay in diagnosis can be catastrophic ‘ Always rule out ectopic pregnancy’ Counseling on future pregnancies Recurrence rate -12% to 20% Early confirmation of future pregnancy Early USS to confirm site of pregnancy
- 5. Ectopic Pregnancy
- 6. Ectopic pregnancy Fetus in ectopic gestational sac Fluid filled uterine cavity Fluid filled uterine cavity & haematoma in pouch of Douglas
- 7. Ectopic Pregnancy: presentation & diagnosis Presentations - acute or chronic Usually symptomatic at 5 - 8 wks POA Pain ++ & ‘minimal’ per-vaginal bleeding Shoulder tip pain & ‘fainting spells’ UPT – mandatory Serum b-HCG Ultrasonography – preferably TVS Diagnostic laparoscopy/ mini-laparotomy
- 8. Ectopic Pregnancy: Management Ruptured - resuscitate & emergency laparotomy Role for conservative management: If serum b-HCG suggests ‘non viable’ ectopic If ‘unruptured’ and asymptomatic If patient staying nearby & able to comply with follow-up Role for medical management: If gestational sac 3000IU - not likely to work Staying nearby and able to come for follow-up IM Methotrexate 50mg/m 2 /kg -1 st dose b-HCG on D4 & D7- expect a minimum15% decrease
- 9. Ectopic Pregnancy: Management Surgical intervention ~ laparoscopy / laparotomy Laparoscopy – preferred choice Salpingostomy or salpingectomy? Check contralateral tube Completed family? Detailed operative & discharge notes Counsel patient
- 10. ‘ Miscarriage’ 3.5 Week
- 11. Miscarriage: Defined as the expulsion of product of conceptus or fetus less than 500gm or 22 weeks gestation with no evidence of life at delivery Habitual abortion is defined as someone who has had 3 consecutive miscarriages Very early miscarriages can sometime be assumed as delayed period
- 12. Early pregnancy Gestational sac at 5 weeks (TVS) 7 weeks (cord & yolk sac) (TVS)
- 13. 1 st trimester fetus with yolk sac Yolk sac Fetus
- 14. Miscarriage: Types Threatened abortion Inevitable abortion Incomplete abortion Complete abortion Missed abortion Septic abortion Termination of pregnancy (TOP) Habitual abortion
- 15. Miscarriages: Common problem Miscarriage above 15 POA uncommon Very early miscarriages may be mistaken as delayed period Not all miscarriages require ERPOC 60% due to chromosomal abnormalities other causes includes……
- 16. Causes of Miscarriages Uterine structural abnormalities Maternal illnesses Congenital infection Autoimmune diseases (APA) Chemotherapy/radiation Therapeutic TOP Induced TOP by doctor or patient

- 17. Bicornuate uterus
- 18. Submucosal fibroid
- 19. Threatened V Inevitable Per vaginal spotting or minimal bleeding Either no pain or only mild Uterus equals to date Cervix tubular and closed Scan shows viable fetus Slight to heavy per vaginal bleeding Moderate to severe lower abdominal pain Uterus equals to date Cervix shortened and Os may be opened Fetus may or may not be viable on scan
- 20. Incomplete V Complete Moderate or severe pain Moderate to heavy per vaginal loss Uterus less than date Os open and POC may be felt Patient in distress! Had severe pain earlier but now mild or no pain Heavy PV loss earlier but now minimal loss Os usually still open Patient is not distressed Scan may be helpful
- 21. Blighted ovum
- 22. Missed Abortion Patient gives history of absence of symptoms of early pregnancy PV spotting or brownish discharge with slight abdominal discomfort Uterus less than dates Os closed Scan to confirm diagnosis Need to ‘ripen’ cervix before ERPOC
- 23. Septic Abortion Any types of miscarriage complicated with infection esp. criminal abortion Foul smelling PV discharge/bleeding with fever and lower abdominal pain/tenderness Cover with appropriate IV antibiotics for at least 6 hours before ERPOC Continue antibiotics for a total of 14 days
- 24. Termination of Pregnancy: Therapeutic TOP (maternal medical reasons or fetal conditions that is not compatible with life) ‘ Personal wish’ or criminal abortion Medical TOP or Surgical TOP or combination Limited adverse impact for future pregnancy unless complicated with sepsis
- 25. 4D USS: Fetus
- 26. Habitual Abortion 3 consecutive miscarriages Screening of patient required before embarking on next pregnancy but most would be negative Only those with anti phospholipid antibodies (APA) positive can be treated to improve outcome (aspirin/clexane/heparin) 80% still have successful pregnancy
- 27. Miscarriage Management: Assess patient (history/clinically) ‘ Ectopic pregnancy’ need to be ruled out! Refer patient to A&E or EPAU (SGH) If bleeding is moderate to severe and patient in some distress, set up IV line give crystalloids and send by ambulance to A&E Management in hospital as described earlier
- 28. MOLAR PREGNANCY Same concept with miscarriage Uterus bigger than dates USS features suggestive Require S&C – expect massive blood loss, 2 large bore IV lines, GXM 2 units and under GA For uterus > 12 weeks (perform in Specialist hospital) HPE & regular serum beta hCG Follow up for 2 years Not to conceive for at least 1year
- 29. Molar pregnancy
- 30. ‘ Hyperemesis Gravidarum’
- 31. Hyperemesis Gravidarum Exaggerated morning sickness , usually improves after 12 POA Nausea, excessive vomiting, unable to eat or drink followed by dizziness, lethargy and dehydration & significant urine ketones Need hospitalization, usually 1 to 3 days IV fluids D/S alt Hartman 4L/24hrs (1 st day) IV Maxolon 10mg TDS /suppository stemetil
- 32. Hyperemesis Gravidarum Veloxin tablets (meclozine HCL 25mg + pyridoxine HCL 50mg) once a day for mild to moderate hyperemesis Veloxin 1 tab twice per day for severe hyperemesis If symptoms worse in morning can take veloxin at bed time Safe in pregnancy

- 33. Hyperemesis Gravidarum USS required to rule out multiple pregnancy and molar pregnancy Discharge with oral maxolon 10mg PRN Advise to take small but frequent bland meals, stay away from oily and spicy food, consume nourishing fluids and rest Few may suffer till delivery…….
- 34. ‘ Cervical Incompetence’
- 35. Cervical Incompetence Defined as the failure of the cervix to retain pregnancy The cervix is usually less than 25 mm Can also be defined as the ripening (effacement & dilatation) of the cervix in the absence of uterine contractions 1 to 2% incidence and accounts for 20% of mid & early third trimester miscarriages
- 36. Cervical Incompetence
- 37. Cervical Incompetence
- 38. Cervical Incompetence: Etiology Idiopathic (most) Congenital abnormalities (mullerian duct abnormalities) Exposure to diethylstiboesterol (DES) in utero Connective tissue diorders (Ehlers-Danlos Syndrome) Surgical trauma (cone biopsy, diathermy, ERPOC)
- 39. Cervical Incompetence Detailed history of POH and previous mid & early third trimester loss crucial ‘ Painless’, ‘Silent’ & quick delivery in previous pregnancy If history quite suggestive then plan for ‘cervical cerclage’ in the next pregnancy at about 14 to 16 weeks POA If uncertain, assess cervix in the next pregnancy by USS and digital assessment from 12 weeks POA at 2 weekly interval.
- 40. Cervical Cerclage Cervical cerclage can be done either vaginally or abdominally under spinal anesthesia Mersilene tape is used to stitch the cervix shut at the level of the internal Os Tape usually cut and removed at 36 weeks Need to monitor patient for vaginal infection and treat accordingly
- 41. ‘ Severe Pelvic Pain’
- 42. Aetiology of Pelvic Pain Cyclical: Premenstrual syndrome Primary Dysmenorrhoea Pelvic endometriosis Ovulation pain/ Mittelschmertz Idiopathic Non Cyclical Pelvic inflammatory disease Severe endometriosis Pelvic tumours / CA Pelvic congestion syndrome? All In the mind? Surgical causes
- 43. Severe Pelvic Pain: History Cyclical or non-cyclical Acute or Chronic Ask for history of parity, dyspareunia, vaginal discharge, abnormal PV bleeding, Pap smear, dysuria, urinary frequency, haematuria, altered bowel habits, PR bleeding, LOA & LOW Assess severity of symptoms, exacerbating and relieving factors
- 44. Severe Pelvic Pain: Examination Abdominal & vaginal examination Anaemic? Wasted? Mass arising from pelvis? Abdominal distension? Tenderness? Abnormal growth in lower genital tract? USS of pelvis Biopsy of abnormal growth in lower genital tract Tumour markers (serum Ca 125, CEA, AFP) Diagnostic laparoscopy for chronic pelvic pain
- 45. ‘ Painful’ Ovarian Cyst Torsion Haemorrhagic Ruptured Endometriotic cyst Cancer
- 46. ‘ Twisted Ovarian Cyst’ History of severe acute lower abdominal pain usually associated with nausea & vomiting Abdomen tender usually associated with a palpable pelvic mass USS reveal a moderately large ovarian cyst Emergency laparotomy required to ‘safe’ ovary Refer to hospital stat!
- 47. ‘ Ruptured Ovarian Cyst’ Presentation similar to twisted ovarian cyst Patient maybe known to have an ovarian cyst but is not palpable or not seen on USS anymore Evidence of peritonitis Haemoperitoneum? Probably require laparotomy Admit to

hospital ASAP

- 48. ‘ Painful’ Uterine Fibroids 20% women by 35yrs have fibroids Painful fibroids are rare ‘ Red degeneration’ Torsion of pedunculated subserous fibroid Sarcomatous change Look for other causes!
- 49. Acute Pelvic Inflammatory Disease Common due to ‘sexual promiscuity’ Clinical features: young, sexually active, acute lower abdominal pain/tender, fever with or without abnormal vaginal discharge 10 to 14 days of appropriate oral antibiotics: doxicycline or cefuroxime or EES or azithromycin plus metronidazole Confirmation of PID only by laparoscopy (not compulsory, Rx based on suspicion)
- 50. Pelvic Endometriosis Common cause of chronic pelvic pain Common cause of subfertility Medical or/and surgical Rx Recurrence 50% by 5 years ‘ Debilitating’ disease
- 51. ‘ Acute Pelvic Pain ’ Ectopic pregnancy Inevitable abortion Incomplete abortion Twisted ovarian cyst Haemorrhagic ovarian cyst Ruptured ovarian cyst Uterine rupture Uterine inversion Acute appendicitis Meckel’s diverticulitis Ureteric calculi Acute cystitis Trauma Pelvic fracture
- 52. ‘ Massive Menstrual Blood Loss’
- 53. ‘ Menstrual Loss’ Normal cycle between 21 to 35 days Estimated blood loss less than 80 ml with flow lasting not more than 7 days 60% of women who complains of heavy periods have normal loss Extremely heavy menstrual loss is uncommon and alternative causes such as miscarriage or CA of cervix need to be ruled out If patient complains of heavy periods and has tachycardia or appears pale, admit patient to hospital for Rx…..
- 54. Rx: ‘Massive’ Menstrual Loss IV access and send for blood count Rule out other causes! Transamin 1gm QID and Medroxy progestogen 20mg TDS (provera) to stop bleeding Emergency D&C a possibility! Plan of management needed and may include medical therapy or surgical procedure Role of ‘Mirena’, ‘Novasure’, MEA
- 55. ‘ Emergency Contraception’
- 56. Emergency Contraception ~ In the past… Al-Razi “ First, immediately after ejaculation, let the 2 come apart and let the woman arise roughly, sneeze and blow her nose several times and call out in a loud voice. She then should jump violently backwards seven to nine times”
- 57. ‘ Risk of Conception’ Unprotected sexual intercourse within day 8 till 18 of a regular 28 day cycle Mid-cycle risk is 20-30% Effectiveness - time / percent
- 58. ‘ Morning After Pill’ Yuzpe method , ethinyl estradiol 100 mcg & levonogestrel 0.5 mg stat plus another dose 12 hours later (85% effective) Within 72 hours of sexual intercourse Works the same way as progestogen only regimen but more side effects Examples: Ovral, PC 4, Lo Ovral Alternative: Marvelon, 2 doses of 4 tabs
- 59. ‘ Morning After Pill’ Progestogen only regimen (85% effective) 0.75mg levonorgestrel, 12 hours apart within 48-72 hours after intercourse Efficacy equals or better than ‘Yuzpe’ Prevents ovulation, prevents fertilisation, prevents implantation Examples: Postinor-2, Plan B Alternately: Overette, 2 doses of 20 pills
- 60. Emergency contraception: Plan B : each dose contains 0.75 mg of levonorgestrel and can reduce risk of pregnancy by up to 89% Take 1 white pill within 72 hours after unprotected sex and 1 more white pill 12 hours later Recent research indicates that both doses can be taken at the same time up to 120 hours after unprotected sex The pills are

more effective the sooner they are taken, so take 2 Plan B pills at the same time as soon as possible after unprotected intercourse .

- 61. Ella – emergency contraception Single dose of 1.5mg levonorgestrel Effective up to 5 days of unprotected sex during a fertile period Approved by FDA
- 62. Emergency Contraception Copper IUCD Effective up to 5 days from probable date of ovulation Effective even after several acts of intercourse Failure rate of 2:100 woman years
- 63. ‘ Cover Against STD’ Good practice to provide cover for STD, particularly in rape cases Azithromycin 1 gram stat or Cefuroxime axetil 1 gram stat
- 64. ‘ Thank you’