The Atlantic Provinces
Medical Peer Review

MANAGEMENT OF SPECIFIC DISEASE ENTITIES - Obstetrics & Gynaecology
#1 - SPONTANEOUS MISCARRIAGE

Miscarriage can be defined as the separation of a fetus from the uterus prior to the ability for survival outside the uterus. Expulsion of the entire fetus constitutes a "complete" miscarriage; part of the fetus is an "incomplete" miscarriage. When vaginal bleeding occurs early in pregnancy, with or without uterine contractions, but without cervical dilation, membranes rupture, or expulsion of the fetus, a miscarriage is "threatened". Cervical dilation, membranes rupture or expulsion of products of conception in the presence of vaginal bleeding result in an "inevitable" miscarriage.

Prevalence: **10 - 15% of clinically recognized pregnancies are spontaneously miscarried; when both clinical and biochemical pregnancies are considered 50% are spontaneously miscarried.**

Risk factors: **chromosomal abnormalities; luteal phase defect; incompetent cervix; infection; antifetal antibodies; autoimmune or alloimune disease; drugs; IUD**

Signs & Symptoms:

- ✓ **women of child-bearing age with abnormal vaginal bleeding**
- ✓ **in a previously diagnosed intrauterine pregnancy: vaginal bleeding, uterine cramping, cervical dilation, ruptured membranes, passage of non-viable fetus or products of conception**

Diagnosis:

- ✓ **history & physical**
- ✓ **tests: cultures (gonorrhea & chlamydia); CBC, Rh type; urine HCG; serial serum HCG; imaging: ultrasound**
- ✓ **diagnostic procedures: fetal heart tones with Doppler**
- ✓ **differential diagnosis: ectopic pregnancy; cervical polyps or neoplasms; hydatiidiform mole pregnancy;**

Therapies:

- ✓ **RhoD immune globulin if mother is Rh negative**
- ✓ **complications of D & C include: uterine perforation; infection, bleeding, retention of fetus; depression and guilt (patient may require counselling and reassurance that she did not cause miscarriage)**

	N/A	E	S	D
Clinical history and physical exam are documented.				
It is evident that appropriate tests have been ordered and completed.				
Appropriate therapies are used and regularly reviewed.				

COMMENTS: _____

It is important to note that these guidelines are meant to be of assistance to assessors in making observations. They should not be taken as standards of any of the Atlantic Provinces Licensing Authorities.

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#2 - DYSMENORRHEA

Risk factors: primary: nulliparity; obesity; smoking; family history
secondary: pelvic infection; STD; endometriosis

Etiology: primary: elevated production of prostaglantins
secondary: congenital abnormalities of uterine or vaginal anatomy; cervical stenosis; pelvic infection; adenomyosis; endometriosis; pelvic tumor; uterine polyps, IUD

Signs & Symptoms:
- ✓ mild: pelvic discomfort; cramping or heaviness on or just before 1st day of bleeding
- ✓ moderate: discomfort first 2 - 3 days of menses, accompanied by mild malaise, diarrhea and headache
- ✓ severe: intense, cramp-like pain lasting 2 - 7 days, often with nausea, diarrhea, headache and back or thigh pain

Diagnosis:
- ✓ history & physical
- ✓ lab: urine HCG, cervical cultures, CBC
- ✓ imaging: ultrasound; for secondary, consider laparoscopy
- ✓ differential diagnosis: pelvic or genital infection; complications of pregnancy; missed or incomplete miscarriage; ectopic, uterine or ovarian neoplasm; endometriosis, UTI; complications of IUD

Therapies:
- ✓ dietary supplement of Vitamin B_1; fish oil capsules; low-fat vegetarian diet
- ✓ medications: NSAIDS, oral contraceptives;
- ✓ follow-up: primary: improves with age & parity; secondary: therapy based on underlying cause
- ✓ complications: anxiety & depression; possible infertility from underlying pathology

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#3 – UTERO-VAGINAL PROLAPSE

Risk factors: childbirth; advancing age; connective tissue & neurogenic disorders; COPD
increased abdominal pressure: obesity; abdominal or pelvic tumor; chronic constipation
heavy lifting;

Prevention: Kegel exercises; weight loss; management of co-existent conditions

Signs & Symptoms:

- ✓ asymptomatic; pelvic pressure; back pain; bulging sensation in vagina; dyspareunia
- ✓ difficulty with urination or defecation

Diagnosis:

- ✓ history & physical
- ✓ lab: renal function to r/o ureteral obstruction; urinalysis to r/o UTI
- ✓ imaging: pelvic U/S or CT (selected cases)
- ✓ diagnostic procedures: urodynamic studies; pap smear; appropriate cervical and endometrial biopsies

Treatment:

- ✓ depends on multiple variables: severity of prolapse, age, sexual activity, associated pelvic pathology,
  desirability of future fertility
- ✓ conservative measures: estrogen replacement; pessary use; pelvic floor physiotherapy; surgery if conservative Rx fails or definitive Rx is desired
- ✓ Surgical Options: vaginal hysterectomy; vaginal vault suspension; vaginal repair colpoclesis
- ✓ follow-up: complications: ureteral obstruction and renal failure;
  side effects of pessary use (discomfort, ulcer, infection)

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#4 – ABNORMAL UTERINE BLEEDING

Pathophysiology: anovulation (90% of DUB is anovulatory); mid-cycle bleeding; frequent menses deficiency of luteal phase; prolonged corpus luteum activity; other (polyps, lesions, carcinoma, thyroid, ectopic pregnancy, hydatidiform mole, thyroid)

Etiology:
CA of vagina, cervix, uterus or ovaries
multiple organ pathologies: thrombocytopenia, thyroid or liver disease, hypertension; DM, adrenal disorders
pregnancy; trauma of the cervix, vulva or vagina; other (infection, ectopic pregnancy, mole, blood dyscrasias, medications, excessive weight gain, stress)

Signs & Symptoms:
- ✓ uterine bleeding unrelated to menses; in excess of normal menstrual flow;
- ✓ irregular pattern; rarely painful

Diagnosis:
- ✓ history & pelvic exam
- ✓ tests: determination of ovulatory status: menstrual cycle charting; basal body temperature monitoring
- ✓ pap smear; endometrial biopsy in selected patients; HCG; TSH; PT/PTT; CBC; prolactin
- ✓ imaging: U/S; diagnostic procedures: endometrial biopsy; D & C

Treatment:
- ✓ medications: first line acute emergent non-ovulatory: estrogens, then OCP or progestin
- ✓ acute non-emergent non-ovulatory: estrogen & progesterone
- ✓ non-acute non-ovulatory: OCP; progestin; NSAIDS; progesterone-releasing IUD's; GNRH agonists
- ✓ second line: Danazol; Cyclokapron; surgery: hysterectomy; endometrial ablation

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#5 - VAGINAL BLEEDING DURING PREGNANCY

Risk factors: cervical or vaginal infections; placenta previa or abruption/sub chorionic hemorrhage; previous premature cervical change/preterm delivery.

Etiology: vaginal or cervical causes; bleeding from placenta
1st trimester: implantation; ectopic or molar pregnancy; threatened or spontaneous abortion; subchorionic hemorrhage; vaginal or cervical polyps/ectropion; cervical cancer
2nd or 3rd trimester: vaginal or cervical infection, cervical polyps/ectropion; cervical cancer; cervical trauma (postcoital); placenta previa or abruption; premature cervical change/preterm labour; vasa previa.

Signs & Symptoms:
- ✓ bleeding: characterize amount; painful vs painless; aggravating factors (intercourse, physical activity, digital examination)

Diagnosis:
- ✓ history & physical
- ✓ labs: blood type & screen; quantitative beta HCG (1st trimester); CBC if bleeding profuse; Kleihauer-Betke (2nd and 3rd trimester, depending on amount of bleeding); swabs of cervix/vagina for infection; ensure adequate screening for cervical cancer
- ✓ diagnostic procedures: speculum exam; digital pelvic exam; ultrasound (obstetric +/- endovaginal for cervical length)

Treatment:
- ✓ outpatient vs inpatient (inpatient more likely in 3rd trimester)
- ✓ medications: consider Rhogam if Rh negative; antibiotics for infection; treatments for premature cervical change/preterm labour; misoprostol for missed/incomplete abortion
- ✓ surgery: consider for ectopic pregnancy (versus expectant or medical management with methotrexate); molar pregnancy; consider for missed/incomplete abortion
- ✓ follow-up: depends on clinical presentation; patient should be instructed to report any increase in amount/frequency of bleeding and seek immediate care if experiencing abdominal pain or sudden increased bleeding. Patient should bring for examination any tissue passed vaginally (1st trimester)

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