Gynaecology Guidance for children and young people (YP)

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See also: child sexual assault, vulvovaginitis, abdominal pain, HEADSSS proforma on **Microguide** (Paediatrics & Neonatology > Paediatrics > A-Z)

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Top tips:

- Ask open questions; try to be non-judgemental
- Consider direct questioning on certain topics
- Begin the consultation with the caregiver(s) present; they can make the adolescent feel more at ease, and are a useful source of information. Next, spend time speaking to the adolescent alone; you may choose to bring the caregiver(s) back at the end of the consultation to discuss the management plan and any remaining concerns. Discuss any findings which make confidentiality an issue, particularly in sexually active adolescents, with the patient alone initially
- Always ask HEADSSS and CSE Screening questions
- We routinely consent for a pregnancy test in certain situations e.g. abdo pain in girls > 12
- PV exam is rarely indicated in CED unless h/o trauma and bleeding, foreign body, discharge, rash or concerns about CSA
- Only do PV/speculum exam if you are trained to do so or this would be part of your normal role (i.e. GP trainees may be happy to do this)
- If you are undertaking an intimate exam, you **must** have a **chaperone** (please see the chaperone policy)

Resources

- British Society of Paediatric and Adolescent Gynaecology produce excellent patient information leaflets: **https://britspag.org/patient-info/leaflets/**
- **SHAC handbook 2022**: T drive: integratedsexualhealth/SHAC/Handbook
- **Pelvic Inflammatory Disease (PID) guideline** on Brighton Microguide

Contact list

- **GUM contacts:**
  - Mon – Fri 09:00 – 17:00 - Registrar via bleep **8075;**
  - Mon – Fri 17:00 – 20:00 and Saturday / bank holidays - Registrar on mobile via switch
  - Mon – Sat 20:00 – 09:00 & Sundays - on call GUM / HIV consultant via switch
- **Gynaecology registrar:** bleep **8618 / 8611**
- **Early Pregnancy Unit** (EPU): ext. 64022 (open 08:00 – 18:00 Mon – Fri)
- **Sexual Health & Contraception Service (SHAC) East** (Claude Nicole Centre): ext. 64785 (in hours only)
- **SHAC Central** Morley St: 01273 523388 (Wednesday afternoon YP's clinic)

Gynaecological History

- History of present illness, onset and progression
- Menstrual history- do they have any concerns?
  - Age at menarche, Last menstrual period
  - Cycle frequency, length
  - Amount of flow – not helpful to ask. Instead enquire about functional impact
  - Use of pads vs tampons (tampons increase risk of Toxic shock and retention)
  - Associated symptoms (pain, nausea, headaches, dizziness)
  - Functional impact & school absence
- Contraception and hormonal treatment
  - Current method; satisfaction
  - Previous methods, including complications, reasons discontinued
- Sexual history
  - Are they currently or previously sexually active? Are they intending to have sex anytime soon?
  - Was this consensual – Do you have concerns re Child sexual exploitation or sexual assault? Have they ever felt pressured to do things they didn't want to do?
  - Did they use contraception and STI protection?
  - Timeframe from last intercourse- do they require emergency contraception?
- Infection
  - History of sexually transmitted infections and PID
  - Symptoms of vaginitis and discharge
- Gender and sexual identity
  - Do they feel attracted to girls, boys, both or neither? – Do they feel different from other girls?
- Growth and Puberty
  - Do they think they are growing and developing normally? Do they have any questions or concerns about their development or appearance? – Consider full growth and development history
- Medications and allergies
  - OCP (combined or progesterone only) / depot / other hormonal
  - Tranexamic acid, mefenamic acid
  - Have they received the HPV vaccine?
- HEADSSS
  - Always take the opportunity to undertake a full psychosocial adolescent history – many YP are vulnerable and may be at risk of harm. Consider discussion with senior clinician

Section 1: Common problems:

Retained tampon / foreign body

- Unless you are competent to do so (i.e. GP trainee, previous gynae training), these patients should be referred, following assessment, to the gynaecology registrar.
- **History**: LMP, size of tampons, when last inserted, how do they use the tampons, how often do they change?
- **Examine** for features of toxic shock syndrome
- **PV / Speculum examination**. Gynaecology registrar / SHO will perform to see if tampon / FB can be located. You will need a speculum (ensure small size available if needed) and forceps or a retrieving instrument if tampon found. Ensure cervix fully visualised. Check adnexa. Tampons can get pushed up in to adnexa of vaginal vault. If tampon / FB located, intact and easily removable then attempt to remove. If not easily removable then discontinue exam and contact gynaecology registrar.
- Advise the patient to switch to pads especially in first 2 years of periods; flow is typically lighter and tampons increase risk of retention and toxic shock.

If foreign body present in young girls consider CSA and follow safeguarding guidance. It is likely an EUA will need to be arranged. FB should usually be suspected in pre-menarche girls presenting with blood stained vaginal discharge.

NB. Hymenal Septae: Congenital anomaly. YP may present with retained tampon as it is easily inserted but then becomes stuck behind the septae once it has swelled up with menstrual blood. Refer to gynae registrar

Vaginal Discharge

Have a low threshold for discussing unusual vaginal discharge with the registrar or consultant

If child is pre-menarche or you have concerns, consider CSA and follow safeguarding guidance. Do not ignore

- The range of normal vaginal discharge patterns is wide. White/yellow, non-offensive vaginal discharge is normal in young girls and increases as they become oestrogenised, often with cyclical variation.
- **History** – onset, duration, progression, pain, systemic features, fever, abdo pain. Enquire about sexual intercourse, trauma and foreign bodies. Consider child sexual abuse (CSA - see separate guideline)
- **Blood-stained discharge suggests foreign body**. May require vaginal examination, usually under anaesthetic. Ultrasound scan is not sensitive. Discuss with gynae registrar (may request swabs)
- **Thrush is uncommon in pre-pubertal girls**. If suspected, treat with topical clotrimazole cream 1% or 2%.

- **Vulvovaginitis:** Common condition. **See separate guideline on Microguide**. If discoloured or offensive discharge may indicate bacterial vulvovaginitis. Swab the discharge. **The requesting clinician will need to take responsibility for chasing results** or communicating with a colleague to chase. Treat any confirmed bacterial infection according to sensitivities.

- **Copious, green or offensive discharge**. Consider sexually transmitted infection (STI) or foreign body:
  - Gonorrhoea and chlamydia may present with abnormal vaginal discharge
  - Bacterial vaginosis typically presents with an offensive, fishy-smelling vaginal discharge, without any associated soreness or irritation
  - Trichomonas vaginalis typically presents with yellow frothy discharge with associated vaginal itching and irritation
  - If sexually active, refer to GUM clinic for examination and further assessment.

- **Post-coital bleeding**
  - Cervical ectropion is the leading cause. Other causes include polyps and cervicitis; Malignancy is very rare in young people
  - Risk Factors include taking the **'pill', pregnancy and puberty (think 3 Ps)**
  - Refer back to GP for management

Gynaecological causes of abdominal Pain (See abdominal pain guideline)

- **Differential diagnosis** - Ectopic pregnancy, Acute appendicitis, Functional pain [ovulation / mittelschmerz], PID, sexual intercourse, some contraceptives
- **Mittelschmerz,** or ovulation pain is usually a unilateral lower abdominal pain that occurs during ovulation at approximately 14 days after the onset of a person's last menstrual period (LMP). Pain may be dull or sharp and twinging. It can last up to 2 days and can be managed with simple analgesia.
- **Endometriosis** – very uncommon in YP
- **Ovarian cyst** – may c/o mild pain mid cycle. May experience a 'pop' sensation on the affected side if the cyst ruptures. The abdomen may be mildly tender.

- **Ovarian torsion** – severe pain and abdominal tenderness +/- guarding. Assess for, and manage shock as required. **This is a gynaecological emergency in order to preserve the function of the torted ovary.**

Problems with early pregnancy

Suspect if 6/52 amenorrhoea and positive urine BHCG

1. **Bleeding and / or Pain** may indicate threatened, inevitable or complete miscarriage. Refer to Early Pregnancy Unit for assessment

2. **Hyperemesis (nausea and /or vomiting) u**sually presents 4th-7th week of pregnancy and peaks between 9th and 16th week. If presents **after** 11th week then it is not usually the cause.
   - → Measure weight, ketones, electrolytes, check thyroid. Examine for dehydration.
   - → Measurement of HCG not recommended.
   - → Reassure the nausea and vomiting usually settle by 20 weeks.
   - → Eating plain or bland food, frequent smaller meals high in protein but low in fat and carbohydrates, avoid triggers.
   - → Discuss features to be aware of such as dark urine, pre-eclampsia symptoms (headache, visual disturbance, swelling of hands, feet or face)
   - → If requires antiemetic: Cyclizine, Promethazine, prochlorperazine.
   - → Admit to hospital if >5% weight loss, continued nausea and vomiting despite antiemetics, a confirmed or suspected underlying diagnosis.

3. **Ectopic pregnancy** may present with severe pain and abdominal tenderness.
   - Ruptured ectopic is an emergency - Assess for signs of shock and resuscitate as required.
   - Manage in resus
   - Organise urgent abdominal USS
   - Urgent referral to Gynae registrar **bleep 8618 / 8611**

Sexually Transmitted Infections (STI) & Pelvic Inflammatory Disease (PID)
(see also separate guidance on child sexual abuse)

Please refer to contacts list on page 1 for relevant contact details

1. STI

- Not common in CED. 80% of positive cases are asymptomatic. May present asymptomatic with concerns about risk following unprotected sex or with abdominal or vaginal pain or discharge
- Consider need for emergency contraception and or treatment for STI.
- In most cases it is appropriate to direct the YP to self-refer to the SHAC service. Contact **01273 523388** at the earliest opportunity. The line is open from 09:00 to 17:00 weekdays (12:30-17:00 on Wednesdays) and is closed on weekends. The closest clinics are SHAC East (Claude Nicol Centre opposite Barry building on Eastern road) or SHAC Central (Morley Street east of North Laine).
- If the YP presents on a Friday afternoon or evening and requires urgent treatment, there may be availability at the Saturday GUM clinic. Discuss with on call GUM/HIV Registrar or consultant.
- YP who are able can do a self-taken vaginal sample for chlamydia / gonorrhoea / mycoplasma in CED if directed by SHAC or on advice of GUM/HIV team, however follow up with SHAC will need to be arranged to discuss the result.
- Home testing kits can also be requested for chlamydia, gonorrhoea, syphilis and HIV; the YP should contact SHAC to discuss their needs

2. PID

- Consider when presenting with abdominal pain.
- Symptoms include lower abdominal / RIF / LIF pain, discharge, painful intercourse (dyspareunia), bleeding
- Take a full sexual history and perform urine pregnancy test
- PV examination – Gynaecology registrar should perform
- The gynae registrar may take swabs (i.e. chlamydia, gonorrhoea, mycoplasma). These should be chased by the requesting team or via the CED microbiology folder. Alternatively the YP should be referred to SHAC for advice and further management.
- Treatment – antibiotics and analgesia - may need admission for IV antibiotics if systemically unwell. Discuss with gynaecology team re: antibiotics to use.
- Recommended antibiotics if discharging home for 12 – 17 years:
  - **Ceftriaxone 1g IM stat**
  - **Doxycycline 100mg BD for 14 days**
  - **Metronidazole 400mg BD for 14 days**
- Discuss with GUM/HIV consultant if YP is pregnant.
- Provide patient information leaflet: **https://www.bsuh.nhs.uk/wp-content/uploads/sites/5/2016/09/Pelvic-inflammatory-disease.pdf**

Requests for contraception

Fraser guidelines (England, Wales and Northern Ireland)

► Relevant to contraceptive advice for YP under the age of 16.
► The following conditions need to be met for YP to be given advice or treatment:
– Mature enough to understand the advice and the implications of treatment
– Likely to start or continue having sex regardless of advice or treatment
– Clinician has advised the YP to tell her parents, or to let him / her tell her parents.
– It is in the girl's best interests to give the advice or treatment.

Emergency contraception following unprotected sexual intercourse (UPSI)

The young person may present alone - involvement of parents in discussion is encouraged however if child is Gillick competent **and you do not have safeguarding concerns**, then **parents do not legally have to be informed** or asked before prescribing emergency contraception.

- Undertake a full HEADSSS and CSE screening. Use HEADSSS proforma
- Consider the age of the child and partner and whether or not referral to social care is warranted (see separate CSA guideline). **If under 16 always refer to health advisor at SHAC East (Claude Nicol Centre)** and offer STI screening.
- No routine follow-up needed. Always advise on ongoing contraception for rest of cycle (delayed ovulation with Levonelle and UPA) and refer to GP or signpost to SHAC to offer ongoing contraception.
- For further information about emergency contraception interactions and re-starting usual contraception refer to the BNF: https://bnfc.nice.org.uk/treatment-

summary/contraceptives-interactions.html and https://bnfc.nice.org.uk/treatment-summary/emergency-contraception.html

- The following options are available within a safe timeframe. Where possible provide outpatient prescription or direct to SHAC (except in urgent time-critical cases).
  1. **Levonelle** (oral progesterone only) – Only effective before LH surge (day 12-14) of cycle. Can be used up to 72 hours post UPSI (may be used between 72-96 hours after UPSI but efficacy decreases with time). **Needs double dose if BMI >26 / 70kg or if taking enzyme-inducing drugs** – however copper IUD preferable in that situation (see BNF for details);
  2. **Ella One** (Ulipristal Acetate – progesterone receptor modulator) – More effective than Levonelle. For use up to 120 hours after UPSI. Not to be used if taking oral steroids e.g. severe asthma. Effectiveness of UPA may be affected if a progestogen has been taken in 7 days prior to UPA, and a progestogen should be avoided for 5 days after UPA administration.
  3. **Copper IUD** – can be fitted up to 5 days after UPSI or within 5 days of expected ovulation (typically day 19 of a regular 28-day cycle);
- You may need to obtain emergency contraception from adult ED or from the emergency pharmacist.
- Long-Acting Reversible Contraception (LARC) should not be prescribed or managed in CED. Refer to the GP or signpost to SHAC to risk assess and manage.
- Note combined OCP is **CI in obesity** (BMI ≥ 35) due to risks of VTE. Refer to UKMEC for medical eligibility for contraception **FSRH UK MEC - Faculty of Sexual and Reproductive Healthcare**.

- Notes:

- If vomiting occurs within 3 hours of taking a dose, a replacement dose should be taken.
- The next period may be early or late
- Advise to seek medical attention promptly if any lower abdominal pain occurs.

Faculty of sexual and reproductive healthcare advice says this extra advice should be given:

- To use barrier method of contraception
- Pregnancy test should be performed if the next period is delayed by more than 7 days, is lighter than usual, is associated with abdo pain or is not typical for the woman
- Pregnancy test should be performed if hormonal contraception is started soon after use of emergency contraception even if they have bleeding.

Section 2: Other problems you may encounter:

Disorders of uterine bleeding

Background

- Mean age of menarche is now 12-13 years
- In adolescence, periods may be regular for the first 2-3 months followed by irregular periods of variable onset, duration and heaviness
- Irregular, heavy and painful periods are a **very common and normal** phenomenon; rarely is there underlying pathology and is usually managed by GP
- Dysmenorrhoea and menorrhagia are the commonest reason for school absence in adolescent girls.
- **Refer to gynaecology where they are significantly disruptive** to schooling and/or extracurricular activities, not responding to primary care management or complicated by a medical or physical/learning disability
- Ask the patient to keep a symptom diary e.g. using **My menstrual cycle** app

1. Dysmenorrhoea – painful periods

- Topical treatments i.e. heat, wheat bags can be helpful
- There is insufficient evidence to indicate whether any one NSAID is more effective. Alternate paracetamol with ibuprofen for severe pain
- Prescribe **Mefenamic acid 500mg TDS as required** for girls over 12 years if simple analgesia is ineffective (not licensed under 12 years). It is an excellent NSAID useful in dysmenorrhoea and may offer some benefit for menorrhagia. It can be used in conjunction with Tranexamic Acid (**1g TDS for up to 4 days**) for concomitant menorrhagia
- Refer back to GP for consideration of long-acting reversible contraception (LARC)
- Provide a patient information leaflet at discharge: **https://britspag.org/wp-content/uploads/2019/07/Pelvic-Pain-BritSPAG-information-leaflet-2019.pdf**

2. Menorrhagia

- Unhelpful to characterise blood volume - instead, ask about functional impact (flooding, clots, using double protection) and school absence
- Ask about family history of bleeding disorders
- Evaluate for signs of severe anaemia and shock
- Perform **FBC and clotting**
- Discuss with gynae registrar if causing haemodynamic instability / requires blood transfusion / causing severe functional impact
- Consider prescribing **Tranexamic acid 1 g TDS for up to 4 days** during the period (not licensed under 12 years). Reduces blood loss by 50%
- Consider Px Mefenamic acid if dysmenorrhoea (see above)
- Consider treating anaemia with iron supplements and organise GP follow up
- Consider **oral Norethisterone (progesterone only) 5mg TDS for 10 days** and refer to GP to consider combined oral contraceptive pill (COCP)
- Provide a patient information leaflet at discharge: **https://britspag.org/wp-content/uploads/2019/07/Heavy-Periods-Information-leaflet-2019.pdf**

NB Do not prescribe regular contraception from CED – refer to GP for this

3. **Amenorrhoea – absence of periods**

Primary amenorrhoea

'Amenorrhoea with normal pubertal progress of secondary sexual characteristics and no menstruation by 16 years. Uncommon in CED: seen in the context of eating disorders or as incidental pickup

- Differential - constitutional delay (common); Consider imperforate hymen, other disorders of the genital outflow tract, chromosomal disorders (e.g. Turners syndrome)
- Ask about growth, assess pubertal stage, plot height and weight
- Ask GP to refer to gynaecology OPD

Secondary amenorrhoea

Menstruation stopped for 6 consecutive months. Oligomenorrhoea is infrequent periods with cycles >35 days apart (may be feature of PCOS)

- Differential - stress, hyperprolactinaemia, thyroid disorders, PCOS, obesity
- Assess growth & pubertal stage. Enquire about galactorrhoea. Examine Visual fields.
- Ask GP to refer to adolescent gynaecology clinic
- If related to eating disorder (rapid weight loss >10kg, low BMI, or over exercise) follow appropriate guideline.

Polycystic Ovarian Syndrome

- Assess for androgen excess / virilisation – male type acne, hirsutism, temporal balding, striae.
- Girls with suspected polycystic ovarian syndrome (PCOS) should be referred to the endocrine service if they are obese and/or have other endocrine complications of obesity.
- The Rotterdam Criteria for diagnosis are 2/3 of the following features:
  - amenorrhoea or oligomenorrhea;
  - signs or symptoms of hyperandrogenism;
  - ultrasound features of polycystic ovaries. (note - ultrasound features are more difficult to interpret in adolescence as multiple cysts are common)
- 1st line treatment is weight loss; 2nd line is metformin – ask GP to refer to gynae clinic

Disorders of puberty – ask GP to refer to paediatric clinic if concerned

1. **Early menarche / precocious puberty**
   Not commonly seen in CED though may attend if young child develops PV bleeding.

2. **Delayed Puberty**
   Lack of secondary sexual characteristics by age 14.