New one-stop Menstrual clinic

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One Stop Clinics

- New trend in Gynaecology
- Highly efficient if appropriately used

What currently happens?

- GP consultation and referral
- Hospital visit 1 – out-patient assessment
- Hospital visit 2 – scan
- Hospital visit 3 – to discuss scan
- Hospital visit 4 – hysteroscopy under GA
- Hospital visit 5 – discuss findings and future plan

How long does all this take?

- Recent audit : 11-13 months from time of GP referral to formulating a management plan

What is involved?

- Pre-answered questionnaire
- Examination & Speculum to exclude cervical pathology
- Ultrasound scan
- Out-patient hysteroscopy, if indicated
- Endometrial biopsy

Menstrual disorders - role of ultrasound scan

- Exclude local intra-cavity pathology
  polyps, submucous fibroids
- Relationship of fibroids to cavity
  select for trans-cervical resection
- Well accepted by patients

Can ultrasound reliably diagnose endometrial pathology?

	TVS Sensitivity	TVS Specificity	Hysteroscopy Sensitivity	Hysteroscopy Sensitivity
Endometrial polyps	56	97	92	100
Submucous 988585 fibroids	82	85	88	100
Endometrial hyperplasia/ carcinoma	67	89	90	100

Advantages of One stop clinics

- Avoid repeated clinic visits
- Select women for operative hysteroscopy
- More rapid access and treatment
- Financial implications
- Reduction of in-patient waiting list times

Which patients are suitable?

- Premenopausal women
- Women > 40yrs
- Primary symptom is a menstrual symptom
- Heavy/irregular/intermenstrual bleeds
- Symptoms not responded to a 3 months course of 1st line measures

Which patients are not suitable?

- Postmenopausal women
- Women < 40yrs
- Post-coital bleeds
- Virgo intacta
- Menstrual symptom is secondary

How should patients be referred?

- Standard referral form – electronic
- Normal referral letter

Menstrual dysfunction – medical therapy

Menorrhagia

Combined oral contraceptive pill

Tranexamic acid

Non-steroidal anti-inflammatory drugs

Dysfunctional uterine bleeding

Combined oral contraceptive pill

Cyclical progestagens (Provera, Duphaston)

Menstrual dysfunction – Mirena IUS

- Levonorgestrel-containing intrauterine device
- Efficacy: At 18 months, 15% amenorrhoeic **BUT** 11% experience continuous bleeding
- Quality of life issues: proportion of women able to undertake daily activities increased from 23-72%
- Satisfaction: 74% expressed satisfaction

Mirena IUS – Failure rates

	Failure rate
Anderson & Rybo (1990)	20%
Barrington & Bowen-Simpkins (1997)	24%
Crosignani (1997)	11%
Kittleson	20%
AMES	26%

Menstrual dysfunction -hysterectomy

- Too many hysterectomies result in the removal of a normal uterus!
- Internationally, there is a marked variation in hysterectomy rates
- Hysterectomy is associated with extremely high rates of satisfaction in patients

Which patients should be referred?

- Regular periods
- Irregular periods
- Clinically urgent patients

Regular bleeds

- Less likely to have pathology
- Standard 1st line treatments for 3 months
- Scan after 3 months
- Refer if abnormal scan OR empirical treatments not working

Irregular bleeds

- 2 options:
- Primary care management: scan in usual way
- Referral: no need to arrange a scan, it will be done in one-stop clinic

Clinically urgent patients

- Refer to directly to clinic

First generation ablative techniques

- Laser ablation (Goldrath 1983)
- Transcervical resection of the endometrium

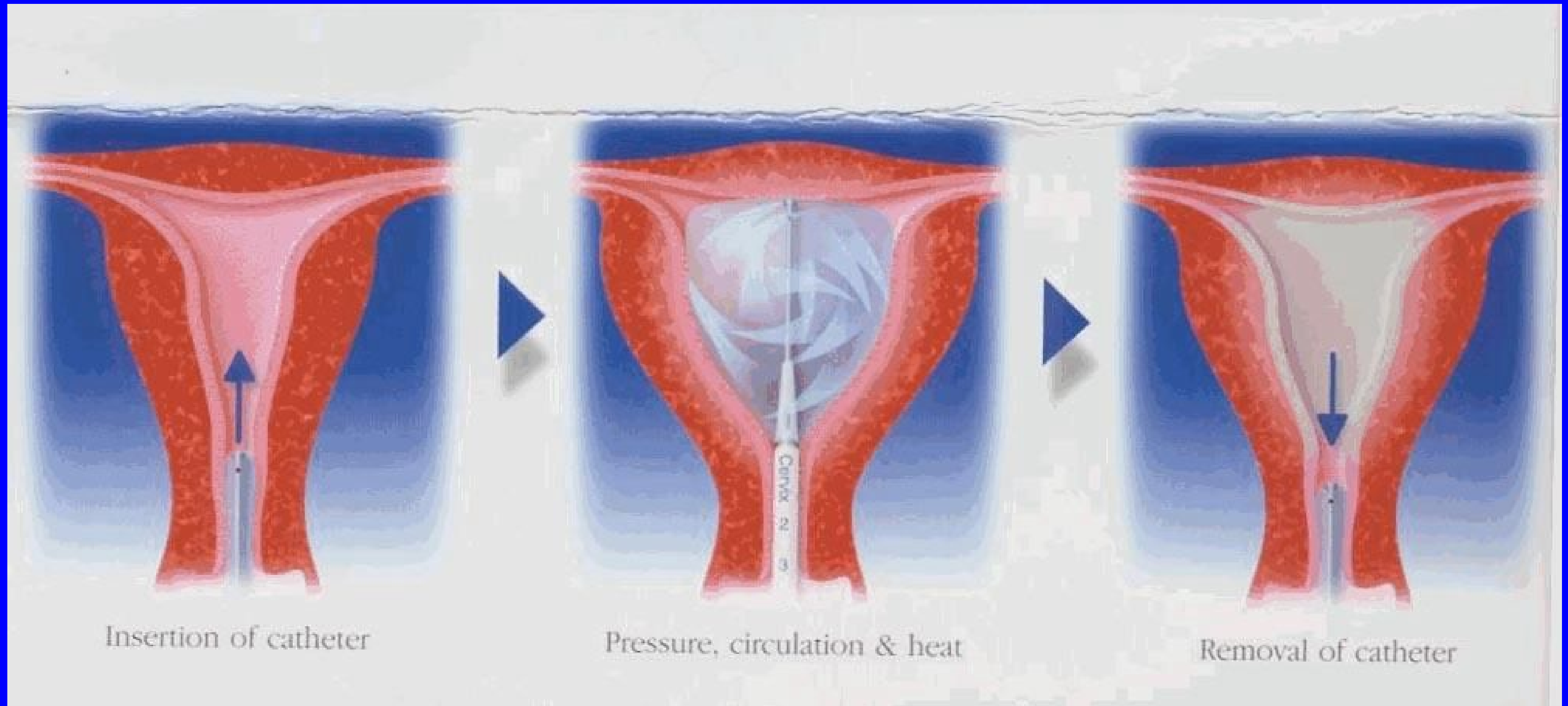
Second generation ablative techniques

- Thermachoice balloon
- Cavaterm balloon
- Microwave ablation
- Hydrotherm ablation
- ELLIT laser ablation
- Versapoint - diagnostic and therapeutic

Balloon ablations

- ~ 20% amenorrhoea rates
- outpatient technique
- 7-8 minutes duration
- low complication rates

Cavaterm balloon endometrial ablation



Menstrual disorders - The future

- Shorter waiting times between referral and treatment
- Shorter waiting times for surgery
- More out-patient procedures
- Fewer unnecessary hysterectomies
- More hysterectomies performed laparoscopically or vaginally