Paediatrics Gynaecological Emergencies

Dr. Akram Khalil
Consultant O&G RBWH
Senior Lecturer UQ
Symptom related

- Pain
- Bleeding/PV loss
- Mass
Main conditions

- PID
- Dysmenorrhea menorrhagia
- Ovary and ovarian cyst accident
- Miscarriage and ectopic pregnancy
- Abuse Sexual/Rape
Organ related

- Vulva
- Vagina
- Cervix
- Uterus
- Tubes
- Ovaries
Assessment

- History
- Examination
- Investigations
- Management
- Resuscitation
Can we take history and from whom?!

- Presenting condition
- Menstrual Periods history and dates for Menarche and of last normal period
- Sexual activity, have she been examine vaginally before, have she been using tampons
- Pap smears and STI
- Past Obstetric history
- Past Medical, surgical history, Family history and contacts
Can we Examine the patient!? 

- General condition
- Vital sign
- Systemic
- Local speculum and vaginal exam.
- Rectal examination
- Examination under anesthetics
Bimanual examination

*Cervical excitation / pelvic tenderness* 
*(PID, ectopic pregnancy, torted ovary)*

*Abdomino/pelvic masses*
Management

- How stable is the patient?
- Does she need resuscitation?
- Does the patient need urgent admission for management?
- Does the patient need admission for assessment?
- Consenting!
Resuscitate if need it
- **WTU** including pregnancy test
- IV access
  - (FBC, ELFTs, **BHCG**, Group & hold/ Cross match and Coagulations profile if need it.)
- IV Fluid / blood
- Oxygen
- Pain relief (morphine / pethedine)
- IDC Fluid chart
- Monitor
Do we have time for…

- Radiological investigations **USS/ CT/ MRI / X-ray**
- Admit to the hospital for observations and medical management
- VS
- OT
  Laparoscopy
  Laparotomy
Non pregnancy related
3y. Old, vulvar itch, and labial adhesion

- Report to the child protective service
- Topical use of estrogen
- Topical hydrocortisone
- Manual separation in the office
- Separation under anaesthesia
Labial agglutination

- **Cause**, unestrogenised vulva
- **Within the first 5/12 of age and may persist to puberty**
- **Asymptomatic, dysuria enuresis infection and retention**
- **Treatment depends on symptoms, estrogen cream**
4y. Old with vulvar pruritus, histology confirm Lichen sclerosus

- *Estrogen cream*
- *Testosterone 2% top*
- *Progesterone 2% top*
- *Top steroid*
- *Emollient ointment*
Lichen sclerosus

- Primarily vulvar disorder
- Common in post menopausal women
- Loss of pigmentation. thinning then loss of anatomy
- May progress to vaginal stenosis, phimosis and ulceration
- Risk of atypia is 4-8%
4y. Old, 2y history of recurrent yellow white vaginal discharge
O/E nil discharge MCS negative

- Vaginitis caused by Candida
- Vaginitis caused by Trichomonas
- Physiological leukorrhea
- Non-specific vulvovaginitis
- Vaginitis caused by Chlamydia
HPV

- Different strains
- Medical eg Aldara cream
- Diathermy
- Excision not advisable
Vulva

Infections
- Vulvar abscess
- Herpes
- Bartholin cyst / abscess
6 y. old few week history of vulvar itch and urine frequency, urine negative for infection, O/E showed urethral prolapse

- Observation
- Hydrocortisone 1% cream
- *Estrogen cream*
- Progesterone cream
- Surgical excision
Urethral prolapse

- Common in age 5-8
- Friable doughnut-shape red-blue mass
- Estrogen deficiency
- Possible inherited anatomical defect in the periurethral tissue
Imperforate hymen
Bartholin gland duct cyst

- Location posterior to the labia majora at 5-7
- Function lubrication
- Incidence 2%
- Cause infection
- D.D. Labial abscess
  - Mesonephric cyst
  - Labial hernia
  - Lipoma, leiomyoma
  - Adenocarcinoma, SCC
Vagina

Lacerations / tears

Foreign body

Vaginitis

- Candida albicans
- Gardenella vaginalis
- Trichomonas vaginalis

Tumors
Cervix

- Infections
  - Chlamydia & gonorrhea
- Erosion ectropion
- Dysplasia / malignancy
- Iatrogenic
  - post op. e.g. LETZ bleeding and infection
uterine

- Dysmenorrhea
- Menorrhagia /Bleeding
- Complications of fibroids
- Bleeding/Benign Malignant
Endometrial polyp
Menorrhagia Dysmenorrhea

- **FBC, TFT, BHCG**
- **Paracetamol, during period**
- **Anti prostagladine, Ibuprofen**
- **Oral contraceptive pills**
- **Progesterone e.g. microlutte Depo-Provera implanton and ? Mirena**
Tubes and ovaries

- Infections PID
- Rupture ovarian cyst incidentals / cyclic
- Endometriosis
- Cancer
Chlamydia trachomatis infection is a major health problem for adolescents and young adults. Studies in primary care and family planning clinics show infection rates of 5% to 14% for those aged 15 to 19 and
Chlamydial perihepatitis (Curtis-Fitz-Hugh-syndrome)
Treat the patient and the partner as in Chlamydia and gonorrhoea

- **Oral Azithromycin 1 g once**, can be repeated in a week
- **Oral Doxycycline 100 mg BD 10 days**
- **Hospitalisation if needed**
- **IV cephalexin/ Ceftriaxone +**
- **IV metronidazole +**
- **IV Gentamycin if needed**
Functional Ovarian cyst
Endometriotic cyst
Dermoid cyst
Dysgerminoma/ Immature teratoma

- **Age teens, most common malignant tumors in young age**
- **Malignant version of dermoid cyst**
- **Tumor markers BHCG, Alpha feto-protein and LDH**
- **Radiologically solid/cystic tumor**
Torsion of the ovary
Pregnancy related

- pain
- Miscarriage
- Ectopic pregnancy
- Hyper emesis
- Incarcerated retroverted uterus
- Infections e.g. chorioamnionitis
- Complications of ovarian cysts
- Complications of fibroids
- Infections e.g. chorioamnionitis
- Complications of ovarian cysts
- Complications of fibroids
Miscarriage

- Threatened
- Inevitable
- Incomplete
- Complete
- Missed/ blightened ovum
- Recurrent
Ectopic pregnancy

- Diagnosis
- Counselling
- Treatment options
- Proper follow up
- Treatment of complication
Diagnostic tips

- **Correlation between BHCG and USS is an important guide to when you can see IUG sac**
- **The role of USS is to exclude intrauterine pregnancy not to confirm ectopic pregnancy**
- **BHCG doubles every 2-3 days**
You can see IUG sac on vaginal USS scan at BHCG as low as

- 800 iu
- 1500 iu
- 2230 iu
- 6500 iu
You can see IUG sac on abdominal USS at BHCG as low as

- 3000 IU
- 5500 IU
- **6500 IU**
- 7000 IU
15 y old 6/40 week amenorrhea presented with pelvic pain O/E severe left iliac fossa tenderness BHCG 1000 iu and pelvic USS reveals no IUG

the next step

- Laparotomy
- Laparoscopy
- Repeat USS in week
- Serial BHCG
- Endocervical culture for chlamydia