CSA EXAMINATION CARD

Patient Name: Sonia Stevens

Examination findings: Not pale. Pulse 70 and regular. Weight 60kg. Height 162 cm. No abdominal masses, organomegaly or tenderness.

If the doctor chooses to do a vaginal examination in the same appointment: The cervix looks normal. The womb is a little bulky. Consistent with fibroids. There are no adnexal masses. The examination is non tender and the vaginal is normal (not atrophic).

GP Trainer's comments - Reviewed by Dr Jane Ancliff February 2019

The Consultation skills are fabulous.

Early on Sonia is asked about what she had read on google and about her concerns. There is skilled summarising and Dr Birrell demonstrates empathy "sounds awful". There is succinct and efficient history taking, without making it doctor centred. I liked the use of "worst case scenario – anything else on your mind" a good phrase that trainees should take to use.

Consent was sought for the abdominal examination and the GP takes the option to defer a pelvic examination, responding to her cues. He explained why the Full Blood Count (FBC) is needed – something I find registrars often omit to do, so this is worth highlighting. Keeping the scan as a future possibility, in case the patient isn't fully reassured by the examination, or for if the symptoms don't settle with medication. The GP acknowledges her concern about cervical cancer and says that this is unlikely. The doctor decides to "re-organise the periods" but checked with the patient: "is that ok?"

Shared management planning: The doctor checks understanding. Specific understanding around the medication regime is checked. Follow up was agreed. It sounds like there was a satisfied customer at the end of the consultation who wishes the doctor a happy Christmas!

***Clinical comments** - Dr Birrell uses the term metrorrhagia, which is technically correct, but NICE and CKS tend to now combine this with menorrhagia and use the term heavy menstrual bleeding (HMB) to cover both. It might be easier for the patient to look up more information on-line and for trainees to do background reading using this term.*

Also NICE recommends that we offer the Intrauterine System (IUS) as the first line medical management. Dr Birrell didn't ask about the patient's contraceptive needs on this occasion, but maybe he already knew. NICE then follow with tranexamic acid or mefenamic acid. The patient said she hadn't tried tranexamic acid yet. Perhaps that could have been more fully explored.

NICE recommends just a FBC as a blood test and specifically mentions no Thyroid Function Tests unless there are other symptoms suggestive of a thyroid problem.

I wholeheartedly agree that this lady needs a gynaecological examination, especially having elicited her concerns around cervical cancer. Although NICE again says this is not always indicated In the absence of additional symptoms. But she did mention pain too.

Additional comments from Dr Suzie Peatman Consultant Gynaecologist

Good history taking and gathering of idea, concerns and expectations. Obviously there is good rapport. I wouldn't expect anything less!
You are correct to assume that these could be age related anovulatory events, but also this could have been triggered by the episode of abdominal pain, which might represent a bleed into an ovarian cyst. This is seen frequently around the time of ovulation. You get a haemorrhage into the follicle / cyst which takes time to resolve and can send the hormones out of kilter. The uterus's only response to hormonal messages is to bleed, or not bleed, and if the hormones are all mixed up then you get a pattern like this.
Thyroid function testing is not indicated in NICE guidelines, if there are no symptoms of thyroid disease, but it is right to check haemoglobin. Gonadotropin levels are largely unhelpful, so it is right not to offer those.
Cancer of the cervix can present like this, but often history of a smelly discharge in that situation which not present in your lady.

Management plan.
An examination needs doing. Some of these women have expelled a uterine fibroid on a stalk through their cervix. Could this account for the pain she had? This fibroid might then bleed, or even necrose. These fibroids need removing. That usually solves the problem.
It is correct to stop her bleeding with a progestogen (eg medroxyprogesterone or utrogestan). I would give her 3 weeks of medroxyprogesterone, and arrange an ultrasound scan to rule out a haemorrhagic cyst/ fibroid in that time. I would then stop the progestogen and tell her to expect a big let down bleed (she could take tranexamic acid 1g qds if needed, to lighten that let down bleed). I would then see if a normal cycle resumes after that, rather than giving a cyclical progestogen for a few months. If erratic bleeding continues when she stops the progestogen, an endometrial biopsy would be indicated at her age.
Norethisterone is a standard progestogen that is widely used but medroxyprogesterone is more modern and nicer to take. We should probably move that way in the future. Medroxyprogesterone is less androgenic.
Hormone replacement therapy is an option, but in the absence of menopause signs and symptoms, it is not indicated. Since she has undiagnosed bleeding she should have an endometrial biopsy, before considering hormone replacement therapy.
We could offer her a Mirena intrauterine system as an alternative treatment option, as anovulatory bleeds are common in the peri-menopause. A Mirena in the uterus will stop the uterine response to the hormonal disruption in the future.
Overall: this was a good assessment of the problem with an effective initial plan of management for primary care.