Central Coast HealthPathways
Cervical Screening Changes and Pill Update

Dr Lynne Hayes

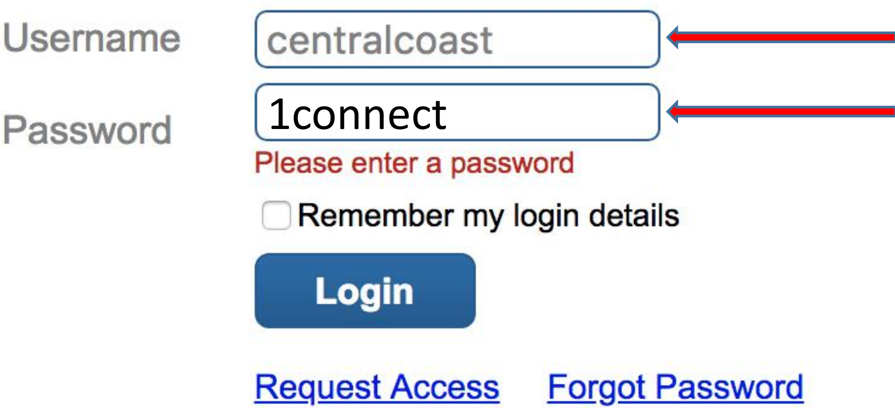
Central Coast NSW
HealthPathways

HNECC PHN acknowledges the traditional owners and custodians of the land that we live and work on as the First People of this Country.

Central Coast NSW

HealthPathways

Log into HealthPathways Central Coast



This website is not for access or use by non-registered health professionals or patients

For login details contact the HealthPathways team on 0438 525 708 or CCHealthPathways@hneccphn.com.au

Central Coast NSW
HealthPathways

About HealthPathways
Contact the HealthPathways Team
Disclaimer

cervical screening Search

Back > Print Send Feedback

- **Home**
- COVID-19
- About HealthPathways
- Acute Services
- Allied Health and Nursing
- Child and Youth Health
- Investigations
- Legal and Ethical
- Lifestyle & Preventive Care
- Medical
- Mental Health
- Older Persons' Health
- Pharmacology
- Public Health
- Specific Populations
- Surgical
- Women's Health
  - Breastfeeding
  - Contraception Options
    - Emergency Contraceptive
    - Combined Hormonal Contraceptives (CHCs)
    - Progestogen-only Pills (POPs)
    - Long-acting Reversible Methods of Contrace
    - Long Term Contraception Referrals
    - Sterilisation
  - Gynaecology
  - Pregnancy
- Our Health System
- Service Directories

Home

Health Alert

NSW Health:

- Infectious Disease Alerts
- Media Releases
- Emergency Preparedness
- Acute Respiratory Infection
- The Role of GPs and Pharmacist Immunisers in Providing Vaccination to Adolescents
- Acute Hepatitis of Unknown Aetiology in Children

See the COVID-19 pathways, including COVID-19 Management, COVID-19 Medications, and COVID-19 Medication Access and Referrals.

About HealthPathways

Education

Useful Websites

Directories

Patient Info

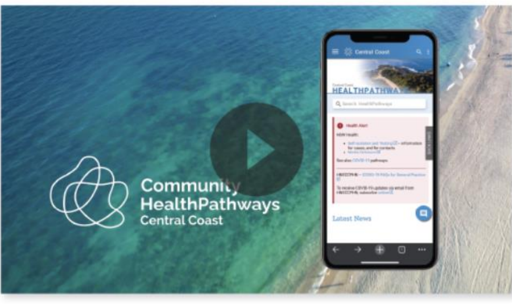
Calculators

PHN Education Library

PBS

About HealthPathways

- What is HealthPathways?
- How do I use HealthPathways?
- How do I send feedback on a pathway?
- How do I add HealthPathways to my desktop?
- How do I add HealthPathways to my mobile?

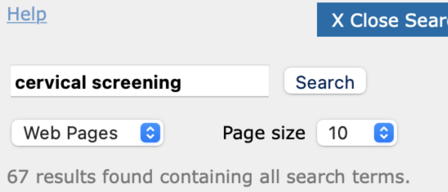


Latest News

HealthPathways goes mobile-friendly

Pathway Updates

Help
X Close Search



cervical screening Search

Web Pages Page size 10

67 results found containing all search terms.

- Cervical Screening
- Cervical Screening Referrals
- Gynaecology Assessment
- Early Antenatal Care
- Practice Incentives Program (PIP)
- STI Screening
- Azathioprine and Mercaptopurine Shared Care Guidance
- Methotrexate Shared Care Guidance
- Heavy or Irregular Menses
- Human Papilloma Virus (HPV)

Pages: 1 2 3 4 5 6 7 Next >>

Back < >

Print Send Feedback

Cervical Screening

COVID-19 note

During the COVID-19 outbreak, it is important to offer and encourage routine screening and follow-up where possible. If it is not possible, follow guidance from the National Cervical Screening Program (NCSP) about when it may be suitable to defer screening appointments, including how to advise the National Cancer Screening Register.

Higher-risk patients should continue to be reviewed without delay, including patients who:

- present with symptoms of cervical cancer.
- are overdue for screening or over age 30 years and never been screened. Offer self-collection as an option.
- are on the Test of Cure pathway after treatment for high-grade squamous intraepithelial lesion (HSIL) (CIN 2/3).
- are due for follow up after an intermediate result (12-month follow up of human papillomavirus (HPV) non-16/18 positive with negative or low-grade cytology). Although it is preferable for these patients to be seen on time, it may be acceptable to delay review for 3 to 6 months.

Last updated: 24 August 2022

Clinical editor's note

All patients are now able to self-collect their own screening sample as of 1 July 2022. See National Cervical Screening Program.

Red flags

- Persistent abnormal vaginal bleeding
- Invasion and/or abnormal glandular cells suggested on liquid-based cytology (LBC)

Background

Red flags

Persistent abnormal vaginal bleeding

Invasion and/or abnormal glandular cells suggested on liquid-based cytology (LBC)

Background

About cervical screening

Assessment

Assess symptomatic patient

Any patient with symptoms or abnormal examination requires further assessment irrespective of a negative screening result.

1. Take a history:
   - Ask about menstrual and gynaecological history, particularly abnormal bleeding or discharge.
   - Determine previous cervical screening history. Use the National Cancer Screening Register.
   - Ask about sexual history and risk of sexually transmitted infections (STIs).
2. Determine appropriate screening for the patient:
   - Consider additional support for patients who are under-screened or never screened.
   - Check the screening recommendations.
   - Consider additional screening or diagnostic testing requirements in following circumstances:
     - Patients with symptoms
     - Patients who began sexual activity at a young age (before age 14 years)
     - Immune-deficient patients
     - Diethylstilbestrol-exposed patients
     - Pregnant patients
     - Patients who have had a hysterectomy
     - Patients with cervical and vaginal atrophy

- Patient privacy
- Quick start guides
- NCSP clinical guideline: important changes
- Forms and guidelines
- HPV positivity rates
- Return to Home

Accessing the National Register

The National Cancer Screening Register has released a **Healthcare Provider Portal** and integration with clinical information systems to enable providers (e.g. general practitioners, nurses, and other specialists) to access and submit bowel and cervical screening data electronically in a self-service fashion.

The introduction of the Portal provides an alternative for interacting with the National Register to reduce paper, fax and phone calls, while also making it easier for healthcare professionals to submit information.

For detailed steps on how to be granted access to participant data and manage your patient's participation in the bowel and cervical screening programs, you will need to refer to the Accessing the National Register page. If you experience any issues, call us on **1800 627 701** to speak to a member of our Contact Centre team.

Accessing the National Register

Healthcare provider | Pathology | Colposcopy | Colonoscopy

Healthcare provider

This information is for healthcare providers who provide cervical or bowel screening services for program participants, including:

- general practitioners (GPs)
- nurses trained in cervical or bowel screening
- specialists such as colposcopists, gynaecologists and gastroenterologists
- Aboriginal and Torres Strait Islander healthcare practitioners.

You can use the National Register to:

2. Determine appropriate screening for the patient:
    - Consider additional support for patients who are under-screened or never screened.
    - Check the screening recommendations.
    - Consider additional screening or diagnostic testing requirements in following circumstances:
        - Patients with symptoms
        - Patients who began sexual activity at a young age (before age 14 years)
        - Immune-deficient patients
        - Diethylstilbestrol-exposed patients
        - Pregnant patients
        - Patients who have had a hysterectomy
        - Patients with cervical and vaginal atrophy
3. Discuss screening with the patient, and explain:
    - about the Renewed National Cervical Screening Program (NCSP).

Renewed National Cervical Screening Program (NCSP)

- Test is now a swab to detect HPV which may be present whether or not the woman is vaccinated.
- If HPV is detected, a reflex LBC test will be performed on the same cervical specimen. In the case of self-collection, a clinician-collected sample will need to be obtained for LBC.
- If HPV 16 or 18 is detected, patients will be referred immediately for colposcopy, regardless of cytology result. If this is detected on a self-collected sample, no LBC is necessary for referral to colposcopy.

Reassure the patient that the renewed screening program is evidence-based.

- sample collection options:
    - clinician-collected specimen – still the preferred method of collection if acceptable, as it is suitable for reflex cytology if needed and initial management can be arranged based on the sample. Indicated if symptomatic, usually abnormal vaginal bleeding.
    - clinician collecting a specimen vaginally without a speculum initially.
    - self-collected specimen.

Self-collected specimen

- From July 2022, all patients with a cervix will be offered a self-collect sample.
- Healthcare providers will still need to explain how to collect the sample, provide correct swabs, and give advice on the possible results and needs for follow-up, including possible clinician-collected specimen or colposcopy.
- The sample is self-collected from the vagina, not the cervix, using a simple dry flocked swab.
- The sample should be collected in the surgery (e.g., in the bathroom or behind a screen), and handed to the healthcare provider.
- Healthcare providers should obtain appropriate swabs from their local pathology provider.

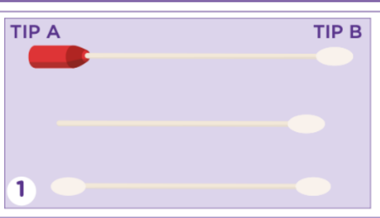
How to take your own sample for a HPV test

Self-collection instructions

To be provided only by a healthcare provider during a consultation

Self-collection is to be completed in a health care setting, behind a screen or in the privacy of a bathroom or toilet. Ask your healthcare provider for help if you are having difficulty with taking the sample, or if you would like them to explain these instructions further.

To collect your own sample, follow these instructions.



1. Before starting

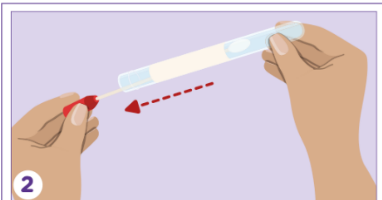
Your healthcare provider will give you a package. Inside is a swab.

Your swab may look different to those pictured here.

Before you open the package, make sure you know which end of the swab can be held (Tip A), and which end is for taking the sample (Tip B). If you are unsure which end is which, ask your healthcare provider for advice.

Before taking the sample make sure your hands are clean and dry.

Make sure you are in a comfortable position and your underwear is lowered.

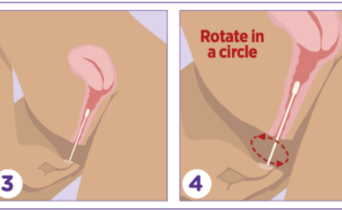


2. Preparing the swab

Twist the cap and remove the swab from the packaging.

Make sure not to touch Tip B that will be inserted to collect the sample.

Do not put the swab down.

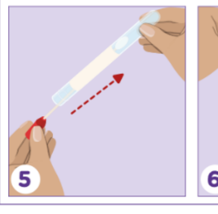


3. Inserting the swab

Use your free hand to move skin folds at the entrance of your vagina. Gently insert Tip B into your vagina (similar to inserting a tampon).
The swab may have a line or mark on it showing you how far to insert.

4. Taking the sample

Rotate the swab gently for 10–30 seconds; this should not hurt, but may feel a bit uncomfortable.



5. Storing the sample

Still holding Tip A, gently remove the swab from your vagina.

Place the swab back into the packaging with Tip B going in first.

Screw the cap back on and return the package to your healthcare provider.

6. Sending the sample

The sample will be sent to a pathology laboratory for HPV testing.

The results of the test will be sent to your healthcare provider.

What if...?

What if I touched Tip B/the swab with my fingers by mistake?	Please continue to take the sample.
What if I dropped Tip B or the swab on a dry surface?	Please continue to take the sample.
What if I dropped Tip B/the swab on a wet surface?	Let your healthcare provider know and ask them for a new swab kit.

Please note if HPV is detected, you will need to return to your healthcare provider for a clinician-collected sample and appropriate management.

Management

1. Refer to a gynaecologist urgently if:
   - persistent abnormal bleeding, even with a normal cervical test.
   - invasion and/or abnormal glandular cells suggested on liquid-based cytology (LBC).

   See also Intermenstrual and/or Post Coital Bleeding and/or Post Menopausal Bleeding pathways.
2. Manage according to screening test results:
   - Self-collected sample test results

Self-collected sample test results

Follow the Cancer Council – Cervical Screening Pathway for Self-collection.

- **Low risk**: If the patient tests negative for HPV, re-screen in 5 years.
- **Higher risk**: If the patient tests positive for oncogenic HPV types 16 and/or 18, request colposcopy. Cervical sample will be taken for LBC at the time of colposcopy.
- **Intermediate risk**: If the patient tests positive for other oncogenic HPV types (not 16 or 18), recall the patient for a clinician-collected sample from the cervix for LBC and manage according to LBC results:
  - Unsatisfactory LBC – retest for LBC only in 6 to 12 weeks.
  - A possible or definite high-grade squamous intraepithelial lesion (HSIL), request colposcopy, aiming for colposcopic assessment within 8 weeks (now higher risk).
  - Any suspected or definitive glandular abnormality, request colposcopy, aiming for colposcopic assessment within 8 weeks (now higher risk).
  - Negative cytology, or possible or definite low grade squamous intraepithelial lesion (LSIL), repeat HPV test in 12 months.
- Manage according to 12-month repeat HPV test result after initial positive oncogenic (not 16/18) test result on self-collected sample:
  - If oncogenic HPV is not detected, ensure the patient returns to routine 5-yearly screening and advise to have a clinician-collected sample at that time.
  - If positive oncogenic HPV (any type), request colposcopy:
    - If the repeat HPV test was clinician-collected, reflex LBC will be available to inform colposcopic assessment.
    - If the repeat HPV test was self-collected, a cervical sample for LBC should be obtained at the time of colposcopy.
- If the patient prefers to have cervical screening done by a female practitioner and this is not possible in their general practice, consider referring for cervical screening.

- Clinician-collected sample test results

CERVICAL SCREENING PATHWAY FOR SELF COLLECTION

Oncogenic HPV test* with partial genotyping

- HPV not detected → Routine 5-yearly screening
- HPV detected (not 16/18) → Cervical sample obtained for LBC**
  - Unsatisfactory LBC → Retest for LBC only in 6–12 weeks
  - Negative → Repeat HPV test in 12 months
  - pLSIL/LSIL → Repeat HPV test in 12 months
    - HPV not detected → Routine 5-yearly screening
    - HPV detected (any type) → Refer for colposcopic assessment cervical sample for LBC obtained at that visit
  - pHSIL/HSIL → Refer for colposcopic assessment cervical sample for LBC obtained at that visit
- HPV detected (16/18) → Refer for colposcopic assessment cervical sample for LBC obtained at that visit
- Unsatisfactory HPV test → Retest HPV in 6–12 weeks

LEGEND

- Primary test
- Reflex test
- Test result
- Recommendation

Woman's risk of developing cervical cancer precursors within the next five years

- Low
- Intermediate
- Higher

* Self-collected

** Healthcare professional visit required

Suggested citation: Cancer Council Australia Cervical Cancer Screening Working Party. Clinical pathway: Cervical screening pathway for self collection. *National Cervical Screening Program: Guidelines for the management of screen detected abnormalities, screening in specific populations and investigation of abnormal vaginal bleeding.* CCA 2016. Accessible from http://wiki.cancer.org.au/australia/Guidelines:Cervical_cancer/Screening

Referral

- Refer to a gynaecologist urgently if:
  - persistent abnormal bleeding, even with a normal cervical test.
  - invasion and/or abnormal glandular cells suggested on liquid-based cytology (LBC).
- Request colposcopy if:
  - the patient is immune-deficient and has a positive test result for HPV (any type).
  - the patient is aged between 70 to 74 years and has a positive test result for oncogenic HPV (any type).
  - the patient tests positive for oncogenic HPV types 16 and/or 18, regardless of the reflex LBC result.
  - initial, repeat, or third HPV test detects HPV 16/18.
  - repeat HPV tests detects HPV non-16/18 in patients aged ≥ 50 years, Aboriginal and Torres Strait Islander patients, or patients overdue for screening by at least 2 years.
  - any HPV is detected on the second follow-up HPV test.
  - other oncogenic HPV types (not 16 or 18) are detected and:
    - possible or definite high-grade squamous intraepithelial lesion (HSIL).
    - any suspected or definitive glandular abnormality (for colposcopy).
  - the patient has history of diethylstilbestrol exposure.
- If cervix looks abnormal or symptoms are present, even if results are normal, request gynaecology assessment.
- If any other concerns, seek gynaecology advice.
- If the patient prefers to have cervical screening done by a female practitioner and not possible in their general practice, consider referring for cervical screening.

Search
- Allied Health and Nursing
- Child and Youth Health
- Investigations
- Legal and Ethical
- Lifestyle & Preventive Care
- Medical
- Mental Health
- Older Persons' Health
- Pharmacology
- Public Health
- Specific Populations
- Surgical
- Women's Health
  - Breastfeeding
  - Contraception Options
  - Gynaecology
    - Amenorrhoea
    - Cervical Polyps
    - Cervical Shock
    - Cervical Screening
    - Chronic Vulvovaginal Candidiasis
    - Dysmenorrhoea
    - Endometrial Cancer Low Risk Follow Up
    - Endometrial Pipelle Biopsies
    - Female Genital Mutilation (FGM)
    - Fibroids
    - Heavy or Irregular Menses
    - Hysteroscopy
    - Intermenstrual and/or Post Coital Bleedir
    - Menopause
    - Ovarian Cyst
    - Pelvic Pain (Chronic)
    - Acute Pelvic Pain in Women
    - Perineal Tear Follow Up
    - Polycystic Ovarian Syndrome (PCOS)
    - Post Menopausal Bleeding
    - Premenstrual Syndrome (PMS)
    - Prolapse
    - Pruritus Vulvae
    - Ring Pessaries
    - Sub-fertility
    - Termination of Pregnancy (TOP)
    - Urinary Incontinence in Women
    - Vulvodynia / Superficial Vulval Pain
    - Gynaecology Referrals
      - **Gynaecology Assessment**
      - Cervical Screening Referrals
  - Pregnancy
- Our Health System
- Service Directories

Print Send Feedback

Gynaecology Assessment

See also Pregnancy Referrals

Private

Gynaecologists

Contact the provider

Gynaecologists with a special interest in menopause

Contact the provider

Gynaecological Oncologists

Contact the provider

Other directories

- Health Direct – Find a Service
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) – Locate an O&G Doctor
- Australian Society of Gynaecologic Oncologists Inc. (ASGO) – Is There a Gynaecologic Oncologist Near You?

Private provider disclaimer

Public

Central Coast Local Health District – Gynaecology Outpatients Clinics

1. Check providers for specific criteria.
2. Prepare the standard referral information
3. Contact the provider.
4. Inform the patient:
   - Ensure they are aware of the referral and the reason for being referred.
   - They should advise of any change in circumstance e.g., getting worse, as this may affect the referral.

Menopause Clinics

1. Check providers for specific criteria.
2. Prepare the standard referral information.
3. Contact the provider.
4. Inform the patient:

Amrou Metawa
Obstetrician, Gynaecologist

North Gosford

Colposcopy, urogynaecologist, endometriosis, pelvic floor prolapse, endometriosis, uterine fibroid, incontinence, menopause, menorrhagia, high risk pregnancy, breech delivery, vaginal birth after caesarian.

Specialist Practice Dr Amrou Metawa

REFERRAL OPTIONS

Phone **(02) 4323-6140**

Fax **(02) 4323-6150**

Information for referrer

Admitting rights to: Gosford Private Hospital, Gosford Public Hospital.

Suite 9, Level 1
Gosford Private Medical Centre
12 Jarrett Street
North Gosford 2250
NSW

Admin contact info

Website Click here

Appointment needed? **Yes**

Service description

Provides the following services:

- Obstetrics **-** Labour and Childbirth, Antenatal Care, Postnatal Care
- Gynaecology **-** Colposcopy, Bleeding disorders, infertility, Polycystic Ovary Syndrome (PCOS), Ovarian Cysts, Fibroids and Reproductive Tumors, Pelvic pain and Endomentriosis, Hysterectomy, Vaginal Atrophy
- Urogynaecology **-** Bladder Dysfunction, Uterine Prolapse

Opening Hours

- Monday to Friday, 9:00am - 5:00pm

Read less

Rajit Narayan
Obstetrician, Gynaecologist

North Gosford

Colposcopy, Maternal Fetal Medicine,

Peter Nelmes
Gynaecologist

Gosford North

Colposcopy, gynaecology, fertility, endoscopic surgery, prolap...

Search

- Home
- COVID-19
- About HealthPathways
- Acute Services
- Allied Health and Nursing
- Child and Youth Health
- Investigations
- Legal and Ethical
- Lifestyle & Preventive Care
- Medical
- Mental Health
- Older Persons' Health
- Pharmacology
- Public Health
- Specific Populations
- Surgical
- Women's Health
  - Breastfeeding
  - **Contraception Options**
    - Emergency Contraceptive
    - Combined Hormonal Contraceptives (CHCs)
    - Progestogen-only Pills (POPs)
    - Long-acting Reversible Methods of Contraception (LAR
    - Long Term Contraception Referrals
    - Sterilisation
  - Gynaecology
  - Pregnancy
- Our Health System
- Service Directories

Back < >

Contraception Options

Background

About contraception options

Assessment

Practice point

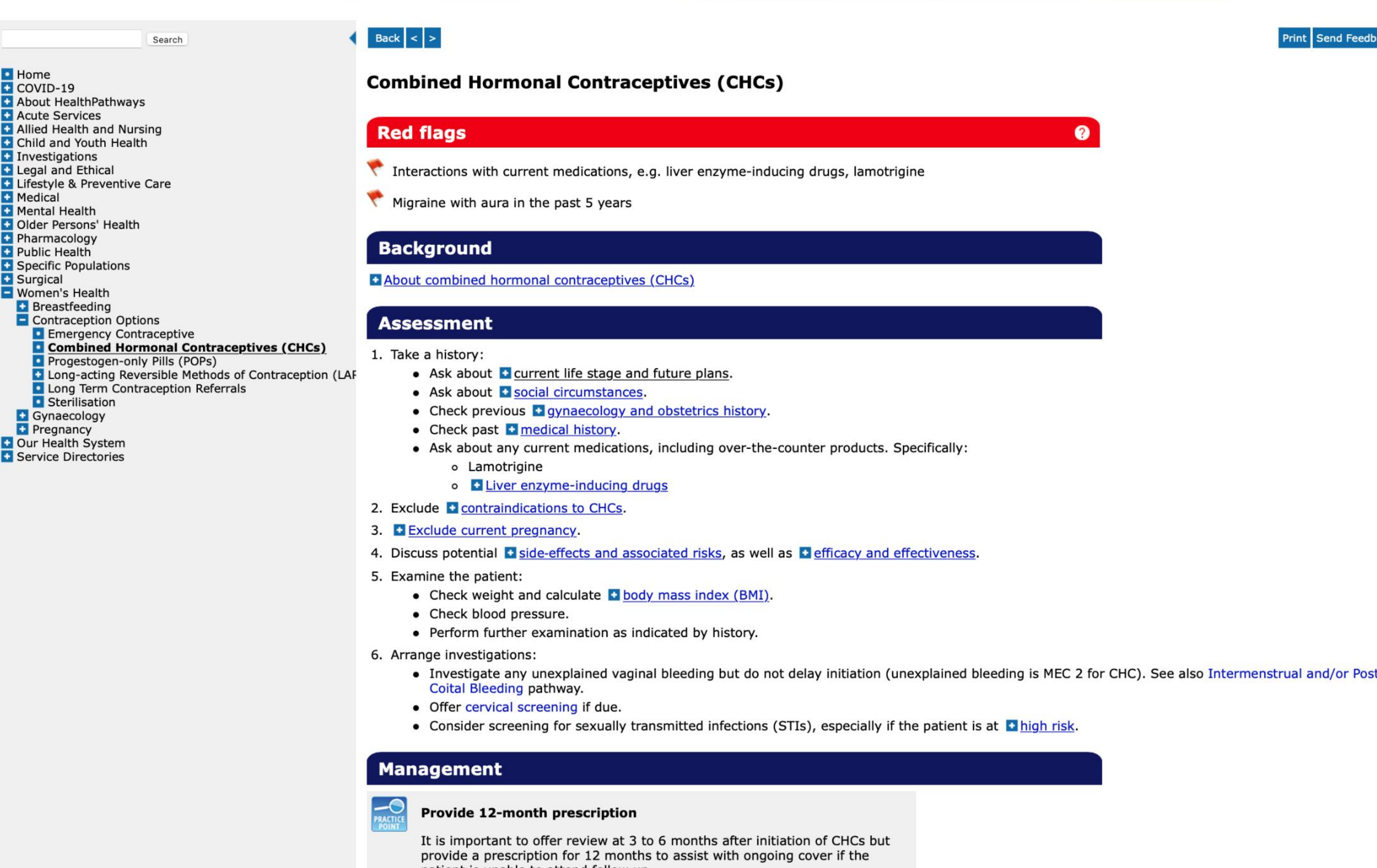
Long-acting reversible contraceptives (LARCs) are recommended in Australia as a first-line contraceptive choice for all eligible women due to their excellent efficacy and safety. [2]

Take a history – consider:
- life stage – adolescent, pregnancy planning, post-partum, perimenopause.
- previous gynaecology and obstetrics history.
- patient preference – experience of previous contraceptives, compliance factors, cost, convenience (daily versus long-acting "set and forget").
- the need for management of related disorders e.g., acne, polycystic ovary syndrome (PCOS), heavy menstrual bleeding, dysmenorrhoea, menstrual migraine, premenstrual syndrome, and perimenopause.
- co-existing medical conditions.
- current medications – may interfere with contraceptive efficacy if used in combination, in particular with liver enzyme-inducing drugs, lamotrigine, and griseofulvin. See The Faculty of Sexual and Reproductive Healthcare – Drug Interactions with Hormonal Contraception.
- smoking status.
- risk of sexually transmitted infections (STIs), particularly considering whether the patient is at high risk of STIs.

2. Exclude current pregnancy before starting contraceptive.
3. Examine the patient if required:
   - Check blood pressure.
   - Check weight and calculate body mass index (BMI). The CHC is not recommended if BMI ≥ 35.
4. Arrange appropriate investigations:
   - Investigate any unexplained vaginal bleeding. See also Intermenstrual and/or Post Coital Bleeding pathway.
   - Consider screening for sexually transmitted infections (STIs), especially if the patient is at high risk of STIs.
   - If active symptomatic STI e.g., chlamydia, gonorrhoea, or pelvic inflammatory disease, delay IUD insertion.
   - Offer cervical screening if due.

Management

1. Provide all patients with sufficient information and guidance to make an informed choice about which contraceptive will best suit their needs:
   - The UK Medical Eligibility Criteria supports safe prescribing for contraceptives.
   - Long-acting reversible contraceptives (LARCs) are recommended in Australia as a first-line contraceptive choice for all eligible women due to their excellent efficacy and safety, but should always be provided within the context of informed choice. [2]
2. Consider life stage.
3. Discuss method options using written information such as the Family Planning Alliance Australia efficacy chart.
4. Advise the patient that most contraceptive methods require additional precautions for a period of time if not started within five days of the start of a normal menstrual period. Exclude current pregnancy and ensure follow-up if at risk of undetected pregnancy.



- Home
- COVID-19
- About HealthPathways
- Acute Services
- Allied Health and Nursing
- Child and Youth Health
- Investigations
- Legal and Ethical
- Lifestyle & Preventive Care
- Medical
- Mental Health
- Older Persons' Health
- Pharmacology
- Public Health
- Specific Populations
- Surgical
- Women's Health
  - Breastfeeding
  - Contraception Options
    - Emergency Contraceptive
    - **Combined Hormonal Contraceptives (CHCs)**
    - Progestogen-only Pills (POPs)
    - Long-acting Reversible Methods of Contraception (LAR
    - Long Term Contraception Referrals
    - Sterilisation
  - Gynaecology
  - Pregnancy
- Our Health System
- Service Directories

Combined Hormonal Contraceptives (CHCs)

Red flags

- Interactions with current medications, e.g. liver enzyme-inducing drugs, lamotrigine
- Migraine with aura in the past 5 years

Background

About combined hormonal contraceptives (CHCs)

Assessment

1. Take a history:
   - Ask about current life stage and future plans.
   - Ask about social circumstances.
   - Check previous gynaecology and obstetrics history.
   - Check past medical history.
   - Ask about any current medications, including over-the-counter products. Specifically:
     - Lamotrigine
     - Liver enzyme-inducing drugs
2. Exclude contraindications to CHCs.
3. Exclude current pregnancy.
4. Discuss potential side-effects and associated risks, as well as efficacy and effectiveness.
5. Examine the patient:
   - Check weight and calculate body mass index (BMI).
   - Check blood pressure.
   - Perform further examination as indicated by history.
6. Arrange investigations:
   - Investigate any unexplained vaginal bleeding but do not delay initiation (unexplained bleeding is MEC 2 for CHC). See also Intermenstrual and/or Post Coital Bleeding pathway.
   - Offer cervical screening if due.
   - Consider screening for sexually transmitted infections (STIs), especially if the patient is at high risk.

Management

Provide 12-month prescription

It is important to offer review at 3 to 6 months after initiation of CHCs but provide a prescription for 12 months to assist with ongoing cover if the patient is unable to attend follow-up.

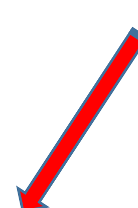
1. Consider individual circumstances which will affect choice and discuss the alternative contraceptive options that are available:
   - Acne

Management

Provide 12-month prescription

It is important to offer review at 3 to 6 months after initiation of CHCs but provide a prescription for 12 months to assist with ongoing cover if the patient is unable to attend follow-up.

1. Consider individual circumstances which will affect choice and discuss the alternative contraceptive options that are available:
   - Acne
   - Adolescents
   - Aged > 35 years
   - Cardiovascular (CVS) risk factors
   - Hirsuitism
   - Menstrual disorders
   - Metabolic syndrome or diabetes
   - Patients on lamotrigine
   - Patients on liver enzyme-inducing drugs
   - Postpartum and/or breastfeeding
   - Premenstrual syndrome
   - Smokers



2. Choose an appropriate contraceptive:
   - from the large range of combined oral contraceptive pills (COCPs) available in Australia, including some newer options, or

     Newer oestrogens
     - Estradiol/estradiol valerate:
       - Chemically identical to 17 beta-estradiol produced by ovaries.
       - Less effect on sex hormone binding globulin (SHBG) and clotting factors.
       - Appears more bone protective than ethinylestradiol.
       - In Qlaira (with dienogest) and Zoely (with nomegestrol acetate).
     - Estetrol:
       - Works selectively on different oestrogen receptors, activating the nuclear receptor but antagonising the membrane receptor (a selective oestrogen receptor modulator).
       - Less proliferative effect on breast epithelial cells in animal studies.
       - Less SHBG induction so likely less effect on circulating androgens.
       - Less impact on coagulation and haemostasis than other oestrogens.
       - Long half-life (24 to 28 hours).
       - In Nextstellis (estetrol with dropirenone), which is effective in women with BMI ≥ 30 (Pearl Index 2.65 in US with 23% obese women), with low rate of adverse events. [5]

   - the combined vaginal ring (NuvaRing).
3. Provide appropriate counselling about using the COCP or NuvaRing, including late or missed pills or ring.
4. Start the CHC:
   - Check last menstrual period and exclude pregnancy, as above. If pregnancy cannot be confidently excluded:
     - Consider emergency contraception if unprotected intercourse within the last 5 days.
     - Inform the patient that except for CHCs containing cyproterone, there is no known harm to her or the fetus if CHCs are used during pregnancy. Cyproterone has a theoretical risk of feminisation of a male fetus.

Progestogen-only Pills (POPs)

Background

About progestogen-only pills (POPs)

Assessment

1. Take a history:
   - Ask about current life stage and future plans.
   - Ask about social circumstances.
   - Check previous gynaecology and obstetrics history.
   - Check current medications. POPs are not recommended in patients taking liver enzyme-inducing drugs:
     - For these patients, consider using a method unaffected by enzyme-inducers e.g., copper or levonorgestrel IUD, or contraceptive injection (DMPA).
     - Women taking a short course of liver enzyme-inducing drugs should use additional contraceptive methods for the duration of the course and for 28 days after cessation of drug.
2. Check for absolute and relative contraindications.
3. Exclude current pregnancy.
4. Discuss advantages and disadvantages of POPs.
5. Discuss potential side-effects:
   - Altered bleeding patterns
   - Other potential side-effects – headaches, mood changes, weight gain, breast tenderness, decreased libido
6. Arrange appropriate investigations:
   - Investigate any unexplained vaginal bleeding. See also Heavy or Irregular Menses.
   - Consider screening for sexually transmitted infections (STIs), especially if the patient is at high risk of STIs.
   - Offer cervical screening if due.

Management

1. Advise on available choice of PBS-listed POPs and non-PBS-listed POPs.
2. Give initiation advice:
   - Noriday 28 and Microlut:
     - Advise the patient that these POPs are effective immediately if started on day 1 to 5 of normal menstrual cycle, or after 48 hours, when 3 consecutive daily pills have been taken, if started any other time in the cycle.
     - Advise the patient that strict adherence to taking a pill at the same time every day is required for maximum effectiveness. There is a 3-hour window for missed pills.
     - Provide written information.
   - Slinda:
     - Advise the patient that this POP is effective immediately if started on day 1 of normal menstrual cycle, or after 7 days of uninterrupted active pills if started at any other time in the cycle (note variance in product information and FPAA advice).
     - Discuss how to start if changing from another form of contraception. See Slinda Australian Product Information.
     - Provide written information.
   - For all POPs, encourage condom use if patient is at risk of STIs.
3. If prescribing Slinda, check serum potassium after one month in patients with chronic kidney disease to assess risk of developing hyperkalaemia.
4. Provide information about how to manage missed pills and disruptions:
   - Noriday 28 and Microlut
   - Slinda

Progestogen-only Pills (POPs)

Background

About progestogen-only pills (POPs)

About progestogen-only pills (POPs)

- There are two types of POPs available in Australia – low dose traditional POPs (often called mini-pills) and a POP which prevents ovulation.
  - Norethisterone 350 microgram (Noriday 28) – PBS-listed mini-pill
  - Levonorgestrel 30 microgram (Microlut) – PBS-listed mini-pill
  - Drospirenone 4 mg (Slinda) – non-PBS-listed
- Norethisterone 350 microgram (Noriday 28) and levonorgestrel 30 microgram (Microlut) primarily prevent pregnancy by thickening the cervical mucus as well as thinning the endometrium, and, in some patients, may prevent or disrupt ovulation. Drospirenone 4 mg (Slinda) primarily prevents ovulation and also thickens cervical mucous and thins the endometrium.
- POPs are a second-line option after LARCs for patients with contraindications to estrogen such as migraine with aura, risk of venous thromboembolism, or arterial vascular disease. They are suitable for women who smoke, are older, or obese, or have hypertension. For patients choosing a POP, the drospirenone POP would be preferable to the low dose mini-pills.
- POPs can also be used by breastfeeding women and can be started immediately after delivery (off label until day 21 for the drospirenone 4 mg POP (Slinda)).
- Norethisterone 350 microgram (Noriday 28) and levonorgestrel 30 microgram (Microlut) come in packs of 28 pills and must be taken at the same time each day, and taken continuously without a hormone-free break. They must be taken no more than 3 hours late to maintain contraceptive efficacy.
- Drospirenone 4 mg (Slinda) comes in packets of 28 pills including 24 active pills and 4 inactive pills (hormone-free break). They have a 24-hour missed pill window.
  - Efficacy is:
    - 91% with typical use (what happens in real life i.e., the actual use of the method, including inconsistent and incorrect use).
    - 99.7% with perfect use (when directions for use are followed at every act of intercourse i.e., the contraceptive method is used consistently and correctly each and every time).
  - While a comparison trial is lacking, the longer 24-hour missed pill window for the drospirenone 4 mg POP compared to the narrow 3-hour window for the levonorgestrel and norethisterone POPs is likely to make it more effective in real life use.
  - Overweight or obese patients do not require higher doses.

Management

1. Advise on available choice of PBS-listed POPs and non-PBS-listed POPs.

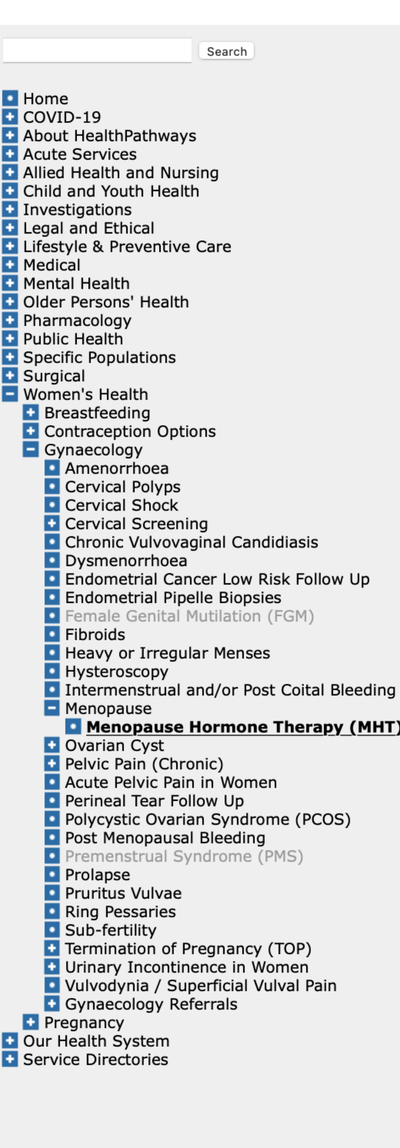
   Non-PBS-listed POPs

   Drospirenone 4 mg (Slinda) – for details, see:

   - Australian Product Information.
   - Slinda Patient Booklet.

   Costs about $30 per month

2. Give initiation advice:
   - Noriday 28 and Microlut:
     - Advise the patient that these POPs are effective immediately if started on day 1 to 5 of normal menstrual cycle, or after 48 hours, when 3 consecutive daily pills have been taken, if started any other time in the cycle.
     - Advise the patient that strict adherence to taking a pill at the same time every day is required for maximum effectiveness. There is a 3-hour window for missed pills.
     - Provide written information.
   - Slinda:
     - Advise the patient that this POP is effective immediately if started on day 1 of normal menstrual cycle, or after 7 days of uninterrupted active pills if started at any other time in the cycle (note variance in product information and FPAA advice).
     - Discuss how to start if changing from another form of contraception. See Slinda Australian Product Information.
     - Provide written information.
   - For all POPs, encourage condom use if patient is at risk of STIs.
3. If prescribing Slinda, check serum potassium after one month in patients with chronic kidney disease to assess risk of developing hyperkalaemia.
4. Provide information about how to manage missed pills and disruptions:
   - Noriday 28 and Microlut
   - Slinda
5. If pregnancy cannot be confidently excluded:



Menopause Hormone Therapy (MHT)

Menopause Hormone Therapy (MHT) is also known as Hormone Replacement Therapy (HRT). See also Menopause.

Background

About menopause hormone therapy (MHT)

Assessment

1. Take a history.
2. Perform examination.
3. Perform tests if indicated.
4. Consider contraindications.
5. Discuss risk versus benefit. For women aged < 60 years, there is no increased mortality with MHT use.
6. Consider if contraception should be continued.
7. Ensure optimal management of co-morbidities, e.g. diabetes and hypertension.

Management

1. Provide joint decision making about the risks and benefits of MHT.
2. Individually tailor MHT.
3. In women:
   - with contraindications, consider alternatives to MHT in menopause.
   - with an intact uterus, use combined MHT.
   - who have had a hysterectomy, use estrogen-only MHT.
   - with a Mirena and amenorrhoeic, use estrogen-only MHT. If spotting develops, perform a pelvic ultrasound to check endometrial thickness.
4. Determine an appropriate MHT regimen. This depends on whether the woman is within 12 months of her final menstrual period (FMP) or still having periods, and whether she has a uterus or not:
   - A woman with a uterus normally requires estrogen with progestogen either cyclically if she is still having periods, or continuously if she is > 12 months from her FMP.
   - A levonorgestrel intra-uterine system (IUS) such as Mirena can be used as the progestogen to protect the endometrium.
   - Estrogens alone are suitable for continuous use in women without a uterus.
   - Estrogens may be given orally or transdermally.
   - In endometriosis, endometrial foci may remain despite hysterectomy. Consider the addition of a progestogen if bowel involvement.
5. Consider tibolone (SERM) as an alternative in women who had their last menstrual period at least 1 year ago and are troubled with persistent unscheduled bleeding, mastalgia, or low libido.
6. If the above therapies are not suitable or endometrial thickness > 5 mm on ultrasound, seek gynaecology advice.
7. If patient asks, advise about bioidentical hormones.
8. Review patients on MHT at least once per year, considering:
   - duration of treatment.
   - new contraindications.
   - change of treatment e.g., from cyclical to continuous or oral to transdermal.
9. Refer for gynaecology assessment if:
   - persistent vasomotor symptoms despite average dose MHT treatment.

Menopause Hormone Therapy (MHT)

Menopause Hormone Therapy (MHT) is also known as Hormone Replacement Therapy (HRT). See also Menopause.

Background

About menopause hormone therapy (MHT)

Assessment

1. Take a history.

    History

    - LMP, severity of symptoms, sleep pattern, mood changes (DASS).
    - Ask if sexually active, and if there are any sexual concerns they wish to discuss. Consider using the Decreased Sexual Desire Screener.
    - Past use of the contraceptive pill and if there were side effects.
    - Family history of breast cancer, bowel cancer or ovarian cancer.
    - Past venous thromboembolism (VTE) or family history of VTE.
    - Presence of cardiac disease, hypertension, osteoporosis or liver disease.
    - Social history.
    - Medicines and supplements.

2. Perform examination.
3. Perform tests if indicated.
4. Consider contraindications.
5. Discuss risk versus benefit. For women aged < 60 years, there is no increased mortality with MHT use.
6. Consider if contraception should be continued.
7. Ensure optimal management of co-morbidities, e.g. diabetes and hypertension.

Decreased Sexual Desire Screener

To be discussed with your health care provider.

Each question is answered Yes or No.

1. In the past, was your level of sexual desire or interest good and satisfying to you?

2. Has there been a decrease in your level of sexual desire or interest?

3. Are you bothered by your decreased level of sexual desire or interest?

4. Would you like your level of sexual desire or interest to increase?

5. Please circle all the factors that you feel may be contributing to your current decrease in sexual desire or interest:

    a. An operation, depression, injuries, or other medical condition

    b. Medications, drugs, or alcohol you are currently taking

    c. Pregnancy, recent childbirth, or menopausal symptoms

    d. Other sexual issues you may be having (pain, decreased arousal, or orgasm)

    e. Your partner's sexual problems

    f. Dissatisfaction with your relationship or partner

    g. Stress or fatigue

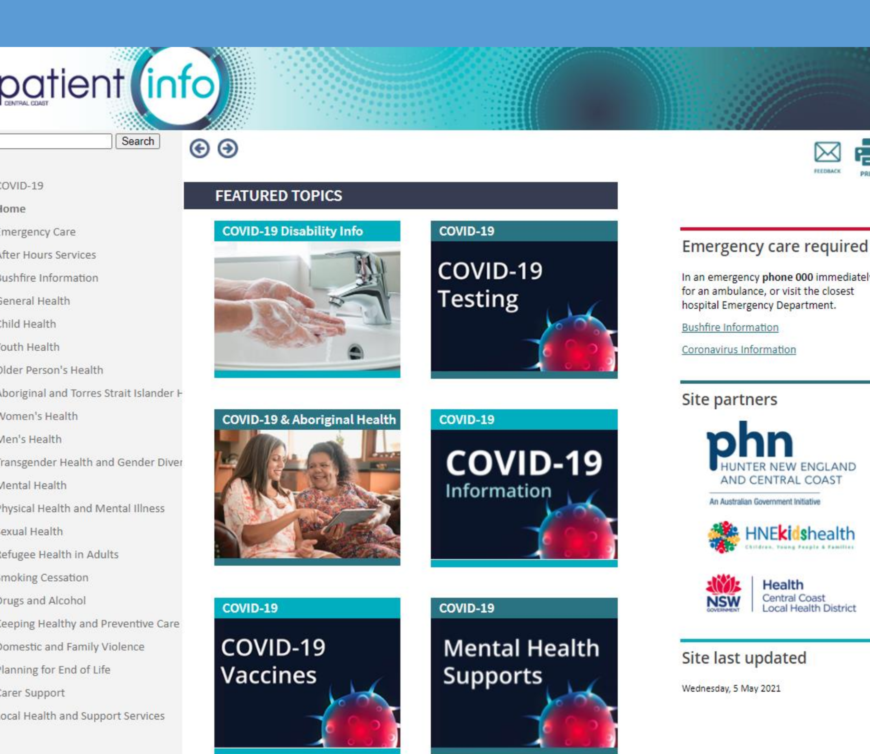
10. See MHT regimen options:

- **Perimenopausal – patient within 12 months of final menstrual period (FMP) or still having periods**
- **Menopausal – patient > 12 months after FMP, uterus intact**
- **Menopausal – patient has had a hysterectomy**
- **Withdrawal from MHT**
- **Compounded bioidentical hormone therapy**
- **Hypoactive Sexual Desire Disorder (HSDD)**

1. Ensure underlying health and relationship issues have been addressed.
2. Trial oestrogen and progestogen and restore vaginal health first, to see if sexual desire and responsiveness is restored.
3. Advise that testosterone declines with age and therapy aims to restore it to normal pre-menopausal levels, which increases libido over about 3 to 6 months.
4. Check testosterone and SHBG at baseline.
5. Consider testosterone replacement if total testosterone is in lower half of normal range:
   - avoid oral oestrogens which raise SHBG. Use patch or gel if needed.
   - start testosterone 1% cream (Androfeme 1, non-PBS) 0.5ml to inner or outer thigh or buttock daily. Rotate sites.
   - check testosterone and SHBG after 3 to 6 weeks (in morning, before application), to ensure testosterone is in upper limit of normal or up to 50% higher (1.5 to 2.5 nmol/L) to avoid acne, hirsuitism and voice change. Reduce dose if too high.
   - titrate to response after 12 weeks, increasing to 1 mL daily if symptoms of sexual function not improved. Rarely increase to a maximum 2 mL.
   - measure testosterone levels at 12 weeks and then 6 monthly.
   - stop treatment after 6 months if no benefit experienced.
6. Consider sildenafil 50 to 100 mg before sexual activity for women on serotonin reuptake inhibitors with associated sexual dysfunction, to improve sexual function. Minor headaches, flushing, and dyspepsia are potential side effects. [7]

Central Coast PatientInfo

https://www.ccpatientinfo.org.au/



Search

- Women's Health
  - Acute Pelvic Pain in Wome
  - Bleeding in Rhesus Negati
  - Breast
  - Cancer
  - Cervical Polyps
  - **Cervical Screening**
  - Contraception
  - Endometriosis
  - Hysteroscopy Referral
  - Intermenstrual and/or Pos
  - Menopause Symptoms
  - Mental Health During and
  - Pelvic Pain
  - Periods
  - Polycystic Ovarian Syndro
  - Post Menopausal Bleeding
  - Pregnancy and Birth
  - Prolapse
  - Screening
  - Sub-fertility
  - Thrush
  - Vulvodynia
- Men's Health

PRINT

Cervical Screening

Cervical screening replaces the Pap Smear or Pap Test from December 1, 2017

- Cancer Institute NSW:

  About Cervical Screening
  - Who is Cervical Screening For?
  - Cervical Screening for Aboriginal Women
  - Where Can I Have a Cervical Screen?
  - How Has Cervical Screening Changed?

  Your Appointment
  - What Happens at a Screening?
  - What Can I Expect at my First Screen?
  - What if I Have Specific Needs
  - Your Cervical Screen Results

  HPV Vaccine
  - What is HPV Vaccine?
- National Cervical Screening Program:
  - Cervical Screening Program (Video)
  - Resources in Other Languages

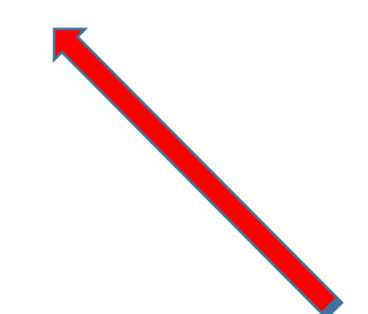
| About Patientinfo | Looking for Hunter New England Patientinfo? Visit their site

This page - 316764 - was last updated on: 4/12/2018 10:21:06 am

Contact Us:

About HealthPathways
Contact the HealthPathways Team
Disclaimer

Print | Send Feedback



Erica Drew
EDrew@hneccphn.com.au
M: 0408 466 480