

How to manage gynaecology on call

Introduction

Obstetrics and gynaecology can be an exciting and rewarding speciality at all levels, but most people feel pretty daunted by both the workload and the fear of the unknown when first handed the gynaecology senior house officer bleep. This is further compounded overnight when you are often covering obstetrics as well. Managing your time between assisting in theatre, ensuring that patients don't breach the 4-hour standard in accident and emergency, reviewing patients on the gynaecology, antenatal and postnatal wards, and keeping up with the jobs expected of the most junior member of the team (e.g. chasing blood results), requires real skill. This article is specifically aimed at foundation doctors and core trainees doing their initial gynaecology on calls, although in practice, you will often be covering obstetrics simultaneously. Here are some top tips to help you through the first few on-calls.

As an obstetrics and gynaecology senior house officer you are often in hot demand. Help yourself by being honest with referrers about how long it will be before you can attend a clinical area. It means people can plan around it, and will not bleep you repeatedly asking where you are. If you are swamped, let your registrar know. He/she can help you prioritize your jobs, see patients with you, and liaise with midwives, nurses and accident and emergency staff on your behalf. If you have a sick patient and are simultaneously needed in obstetric theatres, escalate to your senior colleagues, who can then work out which staff will be most appropriately employed in each situation. Remember that it is always fine to ask for help.

Miss Susanna Crowe is ST7 in *Obstetrics and Gynaecology, Barts Health,*

London E13 8SL and Miss Charlotte

Kingman is *Consultant Obstetrician and Gynaecologist, Homerton University Hospital, London*

Correspondence to: Miss S Crowe
(susanna.crowe@gmail.com)

The referral from accident and emergency

Before you do your first on call, find out whether or not you can do a Cusco speculum examination. If you can't, find a way to learn ahead of your first on call. It might be worth sitting in with a senior in clinic, or going to the gynaecology theatre to get some practice ahead of your first acute shift. It is much better to declare your ignorance at this point than 3 months into the job.

When examining a patient, always offer her a chaperone; if the patient declines, document it in the notes. Give the woman a sheet to drape over herself, and allow her privacy to undress. Choose an appropriately sized speculum. Remember that in the supine position, the vagina goes down and backwards, so angle the speculum down at about 45°. Most uteri are anteverted, so the cervix will lie posteriorly. If you are struggling to find the cervix, locate it with a bimanual examination first. If you still can not find it, get the patient to elevate her pelvis by putting her clenched fists underneath her buttocks. If you can see the cervix but are not getting good views, ask the patient to cough; this often brings it into view.

It is commonly said that the cervix has a poor nerve supply, but even small amounts of dilatation can lead to pain, particularly in nulliparous women. If you examine a patient, and see blood clots or placental tissue within the cervical canal then remove them using a pair of sponge forceps. Not only will this relieve the woman's acute discomfort, but it helps to prevent cervical shock. This is caused by activation of the parasympathetic nervous system on stimulation of the cervix, and can lead to hypotension and bradycardia. The immediate treatment is removal of the stimuli, which usually reverses the shock; in rare instances, atropine may be needed.

Sexual health problems

Make sure you know which swabs your department recommends for sexually transmitted infection screening and testing. Do not take swabs from everyone you examine, make sure you have a good clinical

reason for doing so. Remember, it is your responsibility to chase the results of all tests you have ordered. Explain to the patient what swabs you have taken and why, and make sure you distinguish them from smear tests; patients often assume that they are the same thing.

Be mindful of the fact that patients can still have pelvic inflammatory disease despite negative swabs. *Neisseria gonorrhoeae* and *Chlamydia trachomatis* have been identified as causative agents of pelvic inflammatory disease, but account for only a quarter of cases in the UK (as shown by Bevan et al, 1995). It therefore often remains a clinical diagnosis, unless abscesses are demonstrated on pelvic ultrasound or at laparoscopy. It carries a high rate of morbidity with sequelae such as infertility, ectopic pregnancy and pelvic pain, so a low threshold for empiric treatment is recommended (British Association for Sexual Health and HIV, 2011). Once a diagnosis has been made and treatment instigated, ask the patient to self refer to her local sexual health clinic, as they will follow her up and provide contact tracing for her sexual partners.

Pregnant patients

Early pregnancy problems

Know the result of the urine pregnancy test in all premenopausal women. Do not assume that the referrer knows; ask him/her and check it yourself. If a patient is too unwell to pass urine, then obtain a catheter sample for analysis.

Get yourself an obstetric wheel, so that you can date pregnancies from either the last menstrual period (LMP) or the expected date of delivery (EDD). These are widely available as apps for smartphones.

Be aware that women do not necessarily present in a textbook fashion, i.e. pain before bleeding in an ectopic pregnancy, or bleeding before pain in a miscarriage. Clinical diagnosis of an unruptured ectopic pregnancy is unreliable. Women with an ectopic pregnancy can present with non-gynaecological symptoms, e.g. gastrointestinal disturbance. Equally, ruptured ectopic pregnancy remains a life-threatening condition, and occasionally women will

present with collapse as a result of hypovolaemic shock. Neither the history nor the clinical examination can make a firm diagnosis of an ectopic pregnancy, but these will help determine which women need further assessment, which are stable enough to go home, and which should be offered admission.

Just because a patient's observations are within normal parameters, it does not mean that she has not haemorrhaged, either through miscarriage or a ruptured ectopic pregnancy. Young women compensate cardiovascularly, despite heavy loss. Get an urgent HemoCue to help in your diagnosis. A surgical abdomen with a positive pregnancy test is a ruptured ectopic until proven otherwise. Call your seniors, and insert large bore intravenous access.

Dealing with pregnant patients

Treat all women with early pregnancy complications with kindness and understanding. She may be the fifth woman in a row you are seeing with spotting in the first trimester, but remember that these symptoms cause a huge amount of distress and anxiety in patients (National Institute for Health and Care Excellence, 2012) particularly if there's going to be a wait until a scan provides a diagnosis. Most studies quote a loss of 10–20% in clinically recognized pregnancies, as shown by Elish et al (1996). This fact is well known by doctors, but often comes as a surprise to patients and their families.

You can help to reassure the patient. Ask her about pregnancy symptoms; women who experience nausea and vomiting in the first 12 weeks of pregnancy are almost 70% less likely to miscarry, with a marked increasing trend of reducing odds with increasing severity of nausea (Maconochie et al, 2007). In women who experience bleeding in the first 20 weeks of pregnancy, around 50% will go on to miscarry, as shown by Everett (1997), although this number drops to 14% or less once fetal heart activity has been detected (Mukri et al, 2008). You can point people to useful information on the Miscarriage Association website (www.miscarriageassociation.org.uk), which has helpful guidance for professionals too.

Use sensitive language. Although guidance was published on the nomenclature used to describe pregnancy loss in 2005 in

a paper by Farquharson et al, some textbooks and clinicians have been slow to catch on, and the term abortion is still occasionally and erroneously used. Similarly, use the term 'surgical management of miscarriage' rather than 'evacuation', and refer to 'treatment of a miscarriage' or 'retained placental tissue' rather than 'retained products of conception'.

Prescribing in pregnancy

Clinicians are understandably anxious about prescribing in pregnancy, and here the British National Formulary is your friend. However, it is useful to know that non-steroidal anti-inflammatory drugs are contraindicated in the third trimester of pregnancy, and in practice, are best avoided throughout, unless prescribed by an experienced practitioner. Paracetamol and codeine are safe, although patients will often understandably seek reassurance about this.

When it comes to antibiotics, avoid tetracyclines throughout pregnancy, trimethoprim in the first trimester, and nitrofurantoin in the third trimester. All pregnant women should take 400 µg folic acid in the first trimester (unless they have additional risk factors for neural tube defects, such as obesity or diabetes, in which case the dose is 5 mg), and 10 µg vitamin D throughout pregnancy and breastfeeding. Advise women about this when you meet them. Most over-the-counter pre-pregnancy and pregnancy multivitamins (e.g. Pregnacare) contain the recommended guideline amounts of these supplements.

Understanding anti-D and its administration

One of the things you will frequently be asked to do is to prescribe anti-D. This prevents haemolytic disease of the newborn in future pregnancies, in the event of a rhesus positive fetus sensitizing a rhesus negative mother through feto-maternal haemorrhage. The British Committee for Standards in Haematology guideline on anti-D administration in pregnancy (Qureshi et al, 2014) states that 250 iu intramuscularly should be given in cases under 20 weeks gestation where:

- There is bleeding after 12 weeks
- There is surgical or medical management of miscarriage at any gestation

- There is surgical or medical management of ectopic pregnancy at any gestation

- There is therapeutic termination of pregnancy

- There is a molar pregnancy.

Ideally anti-D should be given within 72 hours of the potentially sensitizing event. It is not required in cases of bleeding under 12 weeks unless there is repeated, heavy bleeding, or it is associated with abdominal pain. After 20 weeks of gestation, the dose rises to 500 iu intramuscularly following a Kleihauer test.

Understanding local protocols

Get to know your unit guidelines. There are some clinical scenarios that you will commonly encounter, such as hyperemesis gravidarum, post-partum hypertension, ovarian hyperstimulation syndrome and miscarriage. Being up to speed on their diagnosis and management from the outset will save you a lot of time and hassle. The ultrasonographic diagnosis of miscarriage should follow the National Institute for Health and Care Excellence (2012) guidelines and it is useful to know where to find this information, as you will occasionally meet patients presenting acutely who come with a scan report from earlier in their pregnancy. It is also useful to get to know your unit guidelines regarding pelvic ultrasound scans, so that you do not order them inappropriately. Most early pregnancy units have protocols, and you can always chat to the consultant or nurse leads to find out what they expect from the other members of the team.

And finally...

Finally, use the resources available to you. There is a wealth of experience and knowledge around you, particularly when it comes to counselling patients, so take the opportunity to sit in with the experts when you get the chance. The Royal College of Obstetricians and Gynaecologists publishes systematically developed recommendations online, known as 'green-top guidelines', also available in an app for iOS. You will also find a variety of useful patient information leaflets on the Royal College of Obstetricians and Gynaecologists website (www.rcog.org.uk). The National Institute for Health and Care Excellence also publishes its guidance in apps, for

both iOS and Android. There are some helpful algorithms in the National Institute for Health and Care Excellence (2012) guidelines.

Always remember there is a wealth of knowledge around you in the form of more senior doctors, nurses, clinical nurse practitioners and midwives, and you should tap into this resource for help whenever you can. **BJHM**

Conflict of interest: none.

Bevan CD, Johal BJ, Mumtaz G, Ridgway GL, Siddle NC (1995) Clinical, laparoscopic and microbiological findings in acute salpingitis: report on a United Kingdom cohort. *Br J Obstet Gynaecol* **102**(5): 407–14

British Association for Sexual Health and HIV (2011) Management of PID 2011 (GC Update June 2011). www.bashh.org/documents/3572.pdf (accessed 1 June 2015)

Ellish NJ, Saboda K, O'Connor JO, Nasca PC, Stanek EJ, Boyle C (1996) A prospective study of early pregnancy loss. *Hum Reprod* **11**: 406–12

Everett C (1997) Incidence and outcome of bleeding before the 20th week of pregnancy: prospective study from general practice. *BMJ* **315**: 32–4

Farquharson RG, Jauniaux E, Exalto N; ESHRE Special Interest Group for Early Pregnancy (2005) Updated and revised nomenclature for description of early pregnancy events. *Hum Reprod* **20**: 3008–11

Maconochie N, Doyle P, Prior S, Simmons R (2007) Risk factors for first trimester miscarriage—results from a UK-population-based case-control study.

BJOG **114**: 170–86

Mukri F, Bourne T, Bottomley C, Schoebb C, Kirk E, Papageorgiou A (2008) Evidence of early first-trimester growth restriction in pregnancies that subsequently end in miscarriage. *BJOG* **115**: 1273–8 (doi: 10.1111/j.1471-0528.2008.01833.x)

National Institute for Health and Care Excellence (2012) Ectopic pregnancy and miscarriage: Diagnosis and initial management in early pregnancy of ectopic pregnancy and miscarriage. NICE clinical guideline. www.nice.org.uk/guidance/cg154 (accessed 1 June 2015)

Qureshi H, Massey E, Kirwan D et al (2014) BCSH guideline for the use of anti-D immunoglobulin for the prevention of haemolytic disease of the fetus and newborn. *Transfus Med* **24**: 8–20 (doi: 10.1111/tme.12091)

Royal College of Obstetricians and Gynaecologists (2010) Surgical Evacuation of the Uterus for Early Pregnancy Loss (Consent Advice 10). www.rcog.org.uk/globalassets/documents/guidelines/ca10-15072010.pdf (accessed 1 June 2015)

TOP TIPS

- Learn how to do a speculum examination as soon as you can. It will help build your confidence, and stop you feeling anxious every time you are called to accident and emergency.
- Remember to always check the documented result of the urine pregnancy test yourself – don't rely on hearsay.
- Get an obstetric wheel app for your smartphone.
- Use the resources available to you – the National Institute for Health and Care Excellence guidelines, the British National Formulary and the Royal College of Obstetricians and Gynaecologists green-top guidelines.

KEY POINTS

- Learn how to prioritize.
- Ask for help.
- Abdominal pain and a positive pregnancy test is an ectopic pregnancy until proven otherwise.
- Always be kind and empathetic, but particularly when dealing with early pregnancy problems.



Stay up-to-date with the **latest developments in midwifery**

Benefits of subscription

- The best, most up-to-date clinical reviews to update your knowledge on important areas of practice
- The latest information on the full spectrum of midwifery
- Support in your professional development
- A monthly journal, delivered direct to you
- An e-newsletter, packed with the latest news, jobs, training and events
- Invitations to our successful FREE study days and roadshows
- Discounts on leading midwifery texts, via Quay Books online store

To subscribe, call 0800 137 201 or visit www.magsubscriptions.com/bjm