



Western Health

phn
NORTH WESTERN
MELBOURNE
An Australian Government Initiative

Common gynaecological challenges – a primary care refresher

Tuesday 11 August 2026

The content in this session is valid at date of presentation



Acknowledgement of Country

North Western Melbourne Primary Health Network would like to acknowledge the Traditional Custodians of the land on which our work takes place, the Wurundjeri Woi Wurrung People, the Boon Wurrung People and the Wathaurong People.

We pay respects to Elders past, present and emerging as well as pay respects to any Aboriginal and Torres Strait Islander people in the session with us today.



Housekeeping – Zoom webinar



All attendees are muted



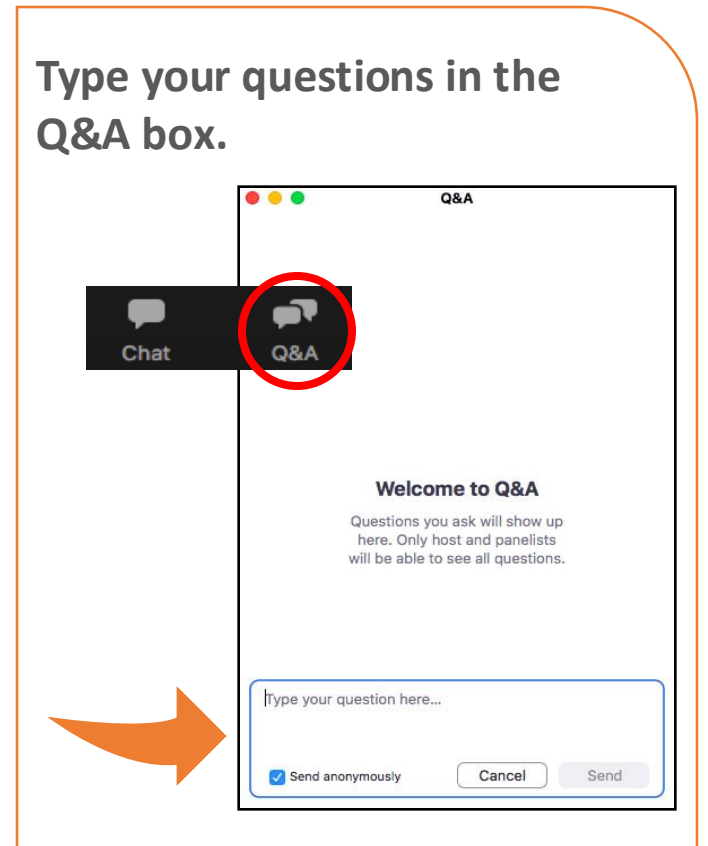
Please ask questions via the Q&A box only

- Q&A will be at the end of the presentation
- Questions will be asked anonymously to protect your privacy



This session is being recorded.

You will receive a link to this recording and copy of slides in post session correspondence.

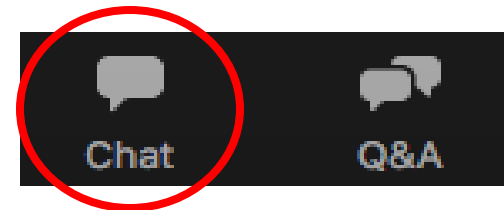


Housekeeping – Zoom webinar

Is your session name the same as your registration?

To ensure we can issue your certificates and CPD please ensure you have joined the session using the same name as your event registration (or phone number, if you have dialled in).

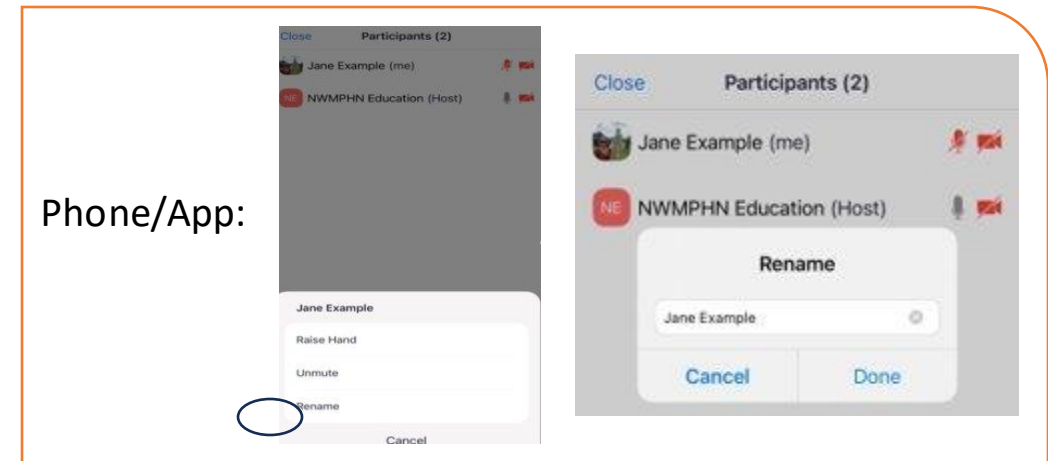
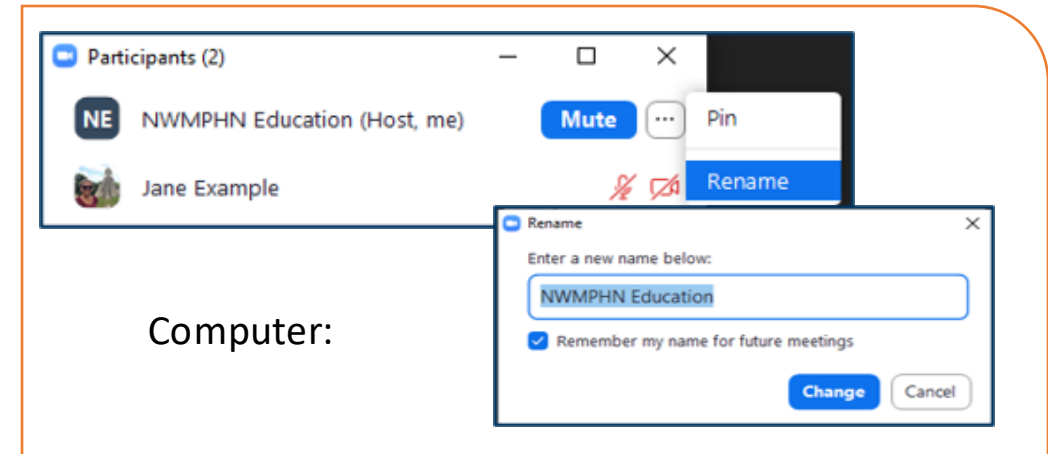
Not sure if your name matches, send a Chat message to 'NWMPHN Education' to identify yourself.



Housekeeping – Zoom webinar

How to rename yourself

1. Click on **Participants**
2. If using
 - App: click on your name
 - Computer: hover over your name and click the 3 dots
 - Mac: hover over your name and click More
3. Click on **Rename**
4. Enter the name you registered with and click **Done / Change / Rename**





Welcome to HealthPathways Melbourne





Localised Clinical Pathways

(Evidence-based guidance adapted for Melbourne clinicians)



Referral Information

(Clear referral instructions for local health services and hospitals)



Regular Updates

(Pathways reviewed and updated regularly by Clinical Editors)



CPD Hours

(Track and record CPD activities directly through Pathway page)



Collaborative Development

(Created by GPs, specialists, allied health and other health professionals)



Easy Access

(Web-based platform, mobile-friendly for point-of-care use)



Streamlined Workflow

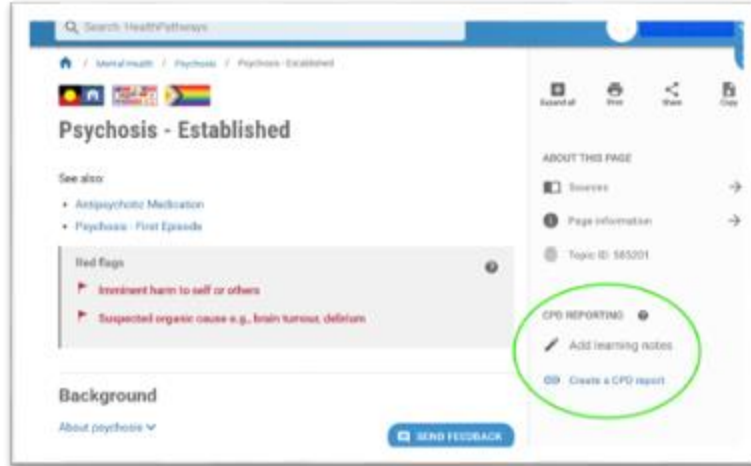
(Quick navigation with Assessment, Management and Referral sections all in one place)



Free for Clinicians

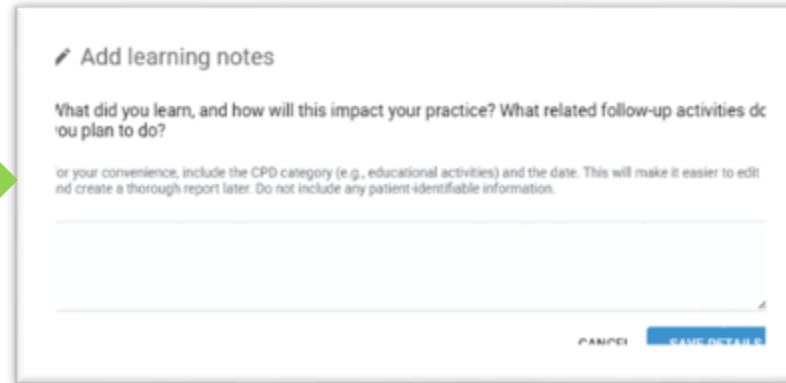
(No cost access for all health professionals in North Western and Eastern Melbourne PHN catchments)

Record Your CPD Today: Start with HealthPathways



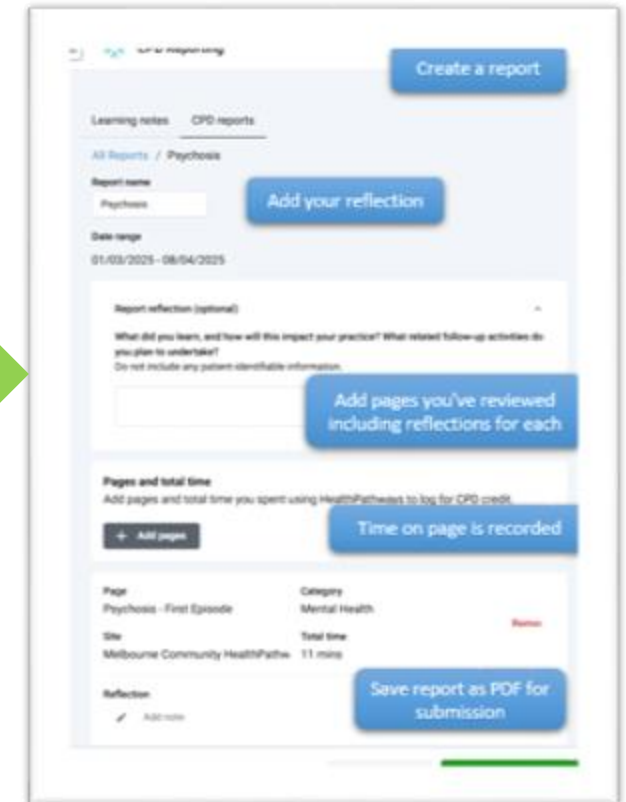
Step 1: Access a Pathway Page

- Navigate to a clinical pathway (e.g., *Psychosis – Established*).
- Click “**Add learning notes**” or “**Create a CPD report**” to begin tracking your CPD activity.



Step 2: Add Learning Notes

- Reflect on what you learned and how it will impact your practice.
- Include any planned follow-up activities.
- These notes are saved to your CPD record.



Step 3: Generate Your CPD Report

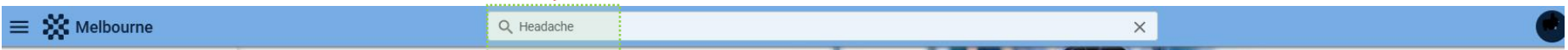
- Go to the **CPD Reporting** section.
- Add reflections, review pages, and confirm time spent.
- Export your report as a **PDF for submission**.

For further information on the CPD reporting tool, please see these videos:

- [How to create a CPD report](#)
- [How to add learning notes](#)

HealthPathways Melbourne Homepage

Search bar for quickly locating clinical pathways and conditions



- Community HealthPathways
- Melbourne
- Medical
 - Assault or Abuse
 - Cardiology
 - Dermatology
 - Diabetes
 - Endocrinology
 - Gastroenterology
 - General Medicine
 - Genetics
 - Haematology
 - Hyperbaric Medicine
 - Immunology
 - Infectious Diseases
 - Intellectual Disability
 - Nephrology
 - Neurology
 - Bell's Palsy
 - Epilepsy in Adults
 - First Seizure in Adults
 - Headaches in Adults
 - Motor Neurone Disease
 - Multiple Sclerosis (MS)
 - Neurofibromatosis
 - Parkinson's Disease
 - Peripheral Neuropathy
 - Postherpetic Neuralgia (PHN)
 - Communicating with Patients with a

Browse clinical suites via left-hand menu, organised into easy to navigate categories



Latest News

- 16 January
- Health.vic**
- Health alerts and advisories
-
- 16 January
- TGA alerts**
- TGA alerts:
- Safety Alerts (for health professionals)
 - Recall Actions (for health professionals)
 - TGA Medicine Shortages (for health professionals)
-
- 16 January
- Measles case**
- A new measles case has been reported in Victoria in a traveller returning from overseas. [Read more...](#)
-
- 8 December
- Nicorandil Shortage – Serious Scarcity Substitution Instrument (SSSI) in Place**
- The TGA has issued an SSSI to manage intermittent shortages of nicorandil tablets until 31 March 2026. Pharmacists can substitute brands/strengths without a new script. See [Substituting Scarce Medicines](#) and [About the Shortage of Nicorandil Tablets](#).

Pathway Updates

- Updated – 16 January
- Animal-related Injury and Illness**
-
- Updated – 6 January
- Sub-fertility**
-
- Updated – 24 December
- Antenatal Care - First Consult**
-
- Updated – 11 December
- Opioid Dependence Treatment (ODT)**
-
- Updated – 8 December
- Bronchiectasis**
- [VIEW MORE UPDATES...](#)

About HealthPathways

- [What is HealthPathways?](#)
- [How do I use HealthPathways?](#)
- [How do I send feedback on a pathway?](#)

Essential quick-access links for latest updates, Pathway updates, clinical resources and MBS items

- ABOUT HEALTHPATHWAYS
- BETTER HEALTH CHANNEL
- RACGP RED BOOK
- USEFUL WEBSITES & RESOURCES
- MBS ONLINE
- NPS MEDICINEWISE
- PBS
- NHSD

Click 'Send Feedback' to add comments and questions about this pathway.

SEND FEEDBACK

Streamlined Navigation of HealthPathways for General Practice

All Sections in One Place: Assessment, Management, and Referral sections on a single page, making it easy for GPs to quickly navigate the entire clinical pathway without switching screens.



Assessment

Headaches in Adults

Practice point

Avoid unnecessary imaging

A detailed history and basic neurological examination is usually enough to differentiate between benign and serious causes. Low-risk headaches generally do not require imaging to exclude a serious cause.

- Take a detailed history. Look for:
 - [Worrying features](#)
 - Reassuring features:
 - Recurrent episodic headache with long history at presentation
 - No neurological deficit
 - Transient neurological symptoms, and occasionally signs, are common features of migraines
- Assess for features of primary headaches:
 - [Tension-type headache](#)
 - [Migraine](#)
 - [Cluster headache](#)
 - [Other primary headaches](#)
 - [Medication overuse headache](#)
- Screen for:
 - [secondary headaches](#)
 - [iatrogenic causes or contributors](#) and ask about over the counter medication use.
- Suggest using a [headache diary](#) to identify [triggers](#), assess self-medication, and aid diagnosis.



Management

Headaches in Adults

Management

- If patient identifies as Aboriginal or Torres Strait Islander, understand their [specific cultural and spiritual needs](#) when discussing and delivering treatment options, including eligibility for [Integrated Team Care \(ITC\) services](#).
- If any [red flags](#), refer to [Emergency Department](#) immediately via ambulance because of the likelihood of an underlying serious cause.
- If suspected brain tumour, refer to a [neurosurgeon](#) linked to a multidisciplinary team within 24 hours.
- For all primary headaches, avoid treatment with opioids, including codeine, due to the risk of medication overuse headaches.
- Address any patient anxiety about serious pathology. Provide reassurance and offer [non-pharmacological management](#), including patient education.
- If chronic headaches, monitor for [depression](#).
- Establish triggers for avoidance.
- Screen for and optimise other possible contributing factors e.g., [obstructive sleep apnoea](#), alcohol consumption, bruxism, adequate daily hydration, or [optometrist review](#) for refractive error.
- Manage patients with primary headaches in general practice:
 - [Tension-type headache management](#)
 - [Migraine management](#)
 - [Cluster headache management](#)
 - [Medication overuse headache management](#)
- If persistent or chronic secondary headache or orofacial pain, and consistent with [statewide referral criteria](#), consider referral to a [Health Independence Program](#) chronic pain service. See Pain Management Referrals.
- Provide patient pain education, as this plays a key role in management.



Referral

Referral

- If any [red flags](#), refer to [Emergency Department](#) immediately via ambulance because of the likelihood of an underlying serious cause.
- If severe intractable migraine attacks, or status migrainosus (a debilitating attack lasting > 72 hours) with significant vomiting and dehydration, refer to the [Emergency Department](#) for intravenous fluids and antiemetics.
- If suspected brain tumour, refer for [acute neurosurgery assessment](#) with access to multidisciplinary team care.
- Request [non-acute neurology referral](#) if:
 - concerning features on neuroimaging (excluding age-appropriate deep white matter hyperintensities).
 - frequent migraine impacting on daily activities despite prophylactic treatment for consideration of calcitonin gene-related peptide antibodies (CGRP) monoclonal antibodies (mAbs) (CGRP MABs) or Botox treatment.
 - migraine diagnosis is in doubt.
 - chronic or atypical headache unresponsive to medical management (tension headache, cluster headache, trigeminal neuralgia, medication overuse headache).
 - acute assessment is not required, but there are [indications](#) for further investigation.
- If severe refractory cases, refer for inpatient withdrawal via [non-acute neurology referral](#) or [chronic or persistent pain referrals](#).
- If prophylaxis for menstrual migraine is ineffective, consider [non-acute gynaecology referral](#).
- If persistent or chronic secondary headache or orofacial pain, and consistent with [statewide referral criteria](#), consider referral to a [Health Independence Program](#) chronic pain service. See Pain Management Referrals.
- If Aboriginal or Torres Strait Islander patient, offer referral to [specific Aboriginal and Torres Strait Islander services](#). For all referrals, to both mainstream and Indigenous services, ensure Indigenous status is clearly marked on the referral.

Click to Expand

Drop-down boxes appear throughout the pathway, click them to view supplementary information.

Click on the Links

Use the interactive links to open related pathways and resources

Stay Informed: Access Case Studies and Monthly Bulletin

Case Study



 Real clinical scenarios for everyday GP practice

- Concise, practical case studies designed to reflect real presentation in General Practice.
- Includes management summaries, pathway links and local service consideration for quick navigation.
- Access all case studies [here](https://melbourne.healthpathways.org.au).

Monthly Bulletin



Monthly updates straight to your inbox

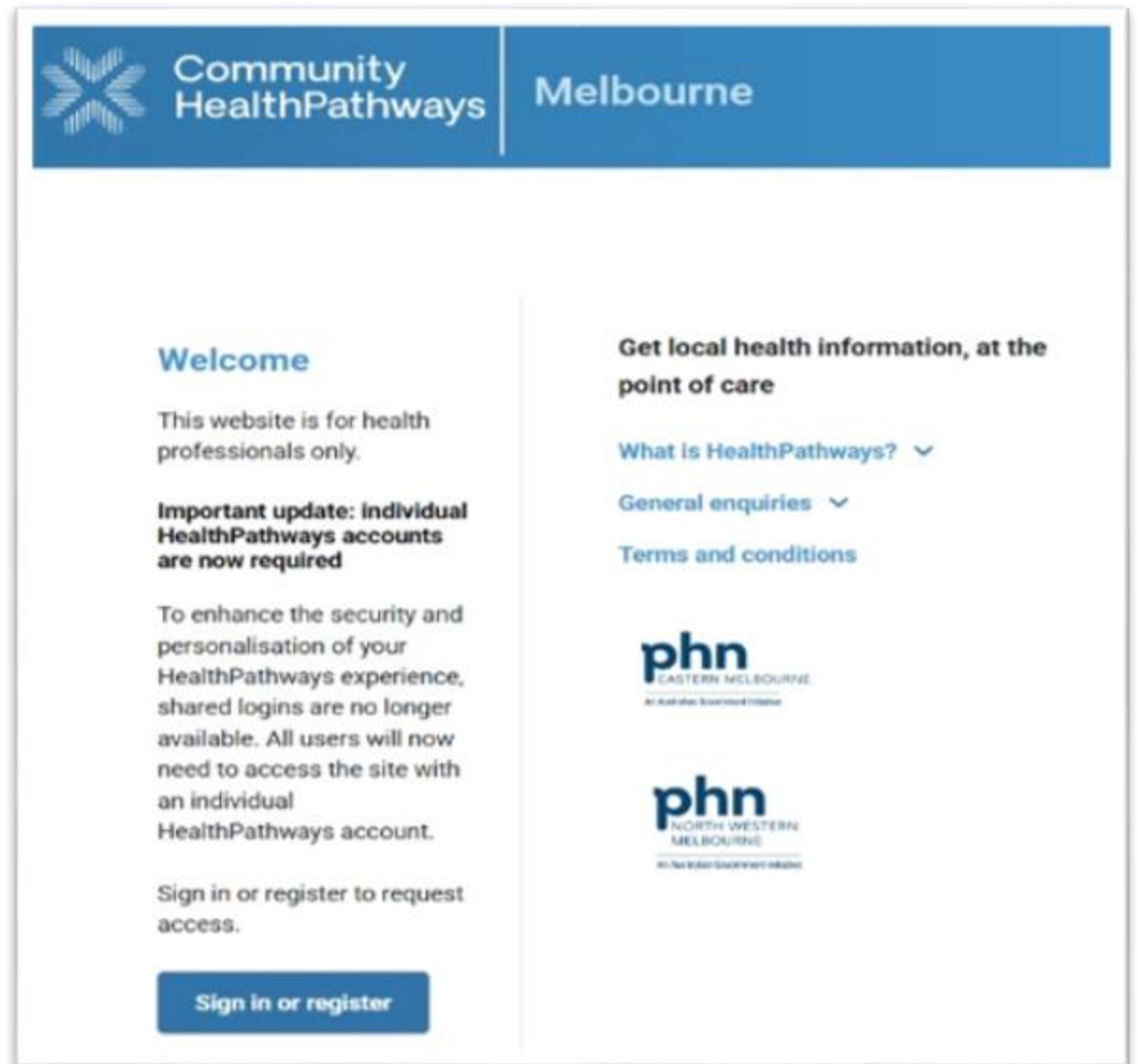
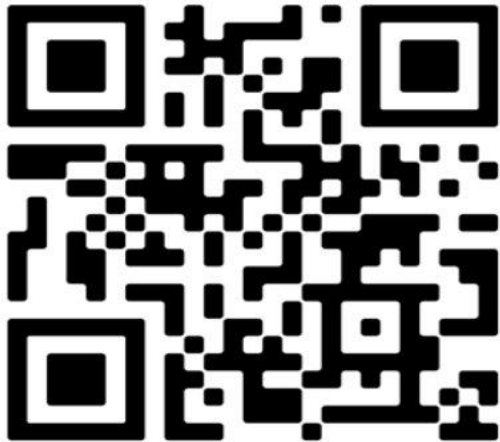
- Be the first to know about pathway updates, service changes , new case studies and employment opportunities

Subscribe to the HealthPathways Melbourne Monthly bulletin or contact us at info@healthpathwaysmelbourne.org.au

Access Now: Sign In or Scan to Register

Please click on the [Sign in or register](#) button to create your individual account or scan the QR code below.

If you have any questions, please email the team info@healthpathwaysmelbourne.org.au

A screenshot of the HealthPathways Melbourne website. The header is blue with a white star icon and the text "Community HealthPathways Melbourne". The main content area is white. On the left, there is a "Welcome" section with a message for health professionals only, an "Important update" about individual accounts, and a "Sign in or register" button. On the right, there is a "Get local health information, at the point of care" section with links for "What is HealthPathways?", "General enquiries", and "Terms and conditions". At the bottom right, there are logos for "phn EASTERN MELBOURNE" and "phn NORTH WESTERN MELBOURNE".



AusCAPPS Network
Community of Practice

A free online network designed to support primary care clinicians to provide **long-acting reversible contraception (LARC)** and **early medical abortion (EMA)** services.

Benefits of joining AusCAPPS

- Connect with GPs, practice nurses, nurse practitioners, midwives, Aboriginal Health Practitioners and community pharmacists who have an interest in providing LARC and/or EMA services in Australia
- Discuss case studies and chat with peers and expert clinicians
- Find providers near you and build local networks
- Get access to the latest evidence-based resources, guidelines, webinars and podcasts
- Keep up to date with education and training opportunities related to LARC and EMA



Join AusCAPPS



Project partners

The AusCAPPS Network is supported by funding from the Australian Government Department of Health, Disability and Ageing.



medcast.com.au/communities/auscapps

✉ AusCAPPS.trial@monash.edu

[in](#) AusCAPPS Network

[f](#) AusCAPPS

Speakers

Dr Sneha Parghi, specialist Gynaecologist VMO at Joan Kirner Womens and Childrens & Director of Maven Centre, Joan Kirner Women's Centre

Committed to providing compassionate, patient-centred care that empowers women to make informed decisions about their health and wellbeing. With extensive experience across leading public and private hospitals in Victoria and Queensland, she has developed expertise in the management of a broad range of gynaecological conditions, with a particular focus on minimally invasive surgical procedures, pelvic pain and endometriosis.

After graduating from the University of Adelaide in 2006, Dr Parghi worked in metropolitan, regional and international healthcare settings, including humanitarian work with Médecins Sans Frontières in Haiti. She completed specialist training in Obstetrics and Gynaecology and subsequently undertook advanced fellowship training in minimally invasive gynaecological surgery before attaining Fellowship of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG).



MAVEN CENTRE
ADVANCED GYNAECOLOGY & WOMEN'S HEALTH



Western Health



**Women's
Health Clinic**

Heavy menstrual bleeding

Dr Sneha Parghi
MBBS FRANZCOG SCCL

Consultant Gynaecologist, Western Health

Clinical lead – Pelvic Pain Clinic, Outpatient Hysteroscopy

Director, Advanced Laparoscopic Surgeon, Maven Centre, St Albans

Outline

- Definition of HMB
- PALM COEIN classification
 - Causes of HMB
 - Investigation
 - Management options



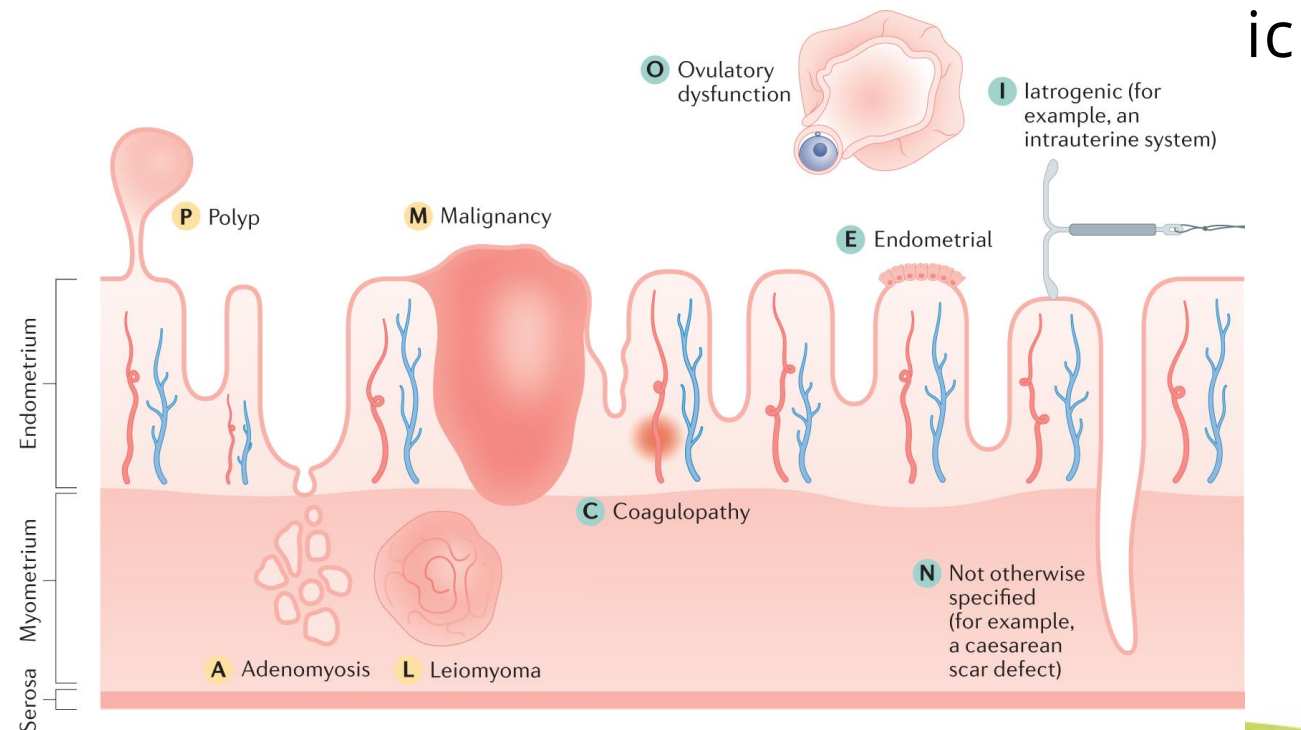
Heavy menstrual bleeding: definition

- » Old-school thinking: total blood lost per period should be < 80mLs
 - > 80mLs = 'menorrhagia'
 - Not practical to measure!
- » New-age thinking: if a woman thinks her period is too heavy, it is too heavy!
 - = **'heavy menstrual bleeding'**

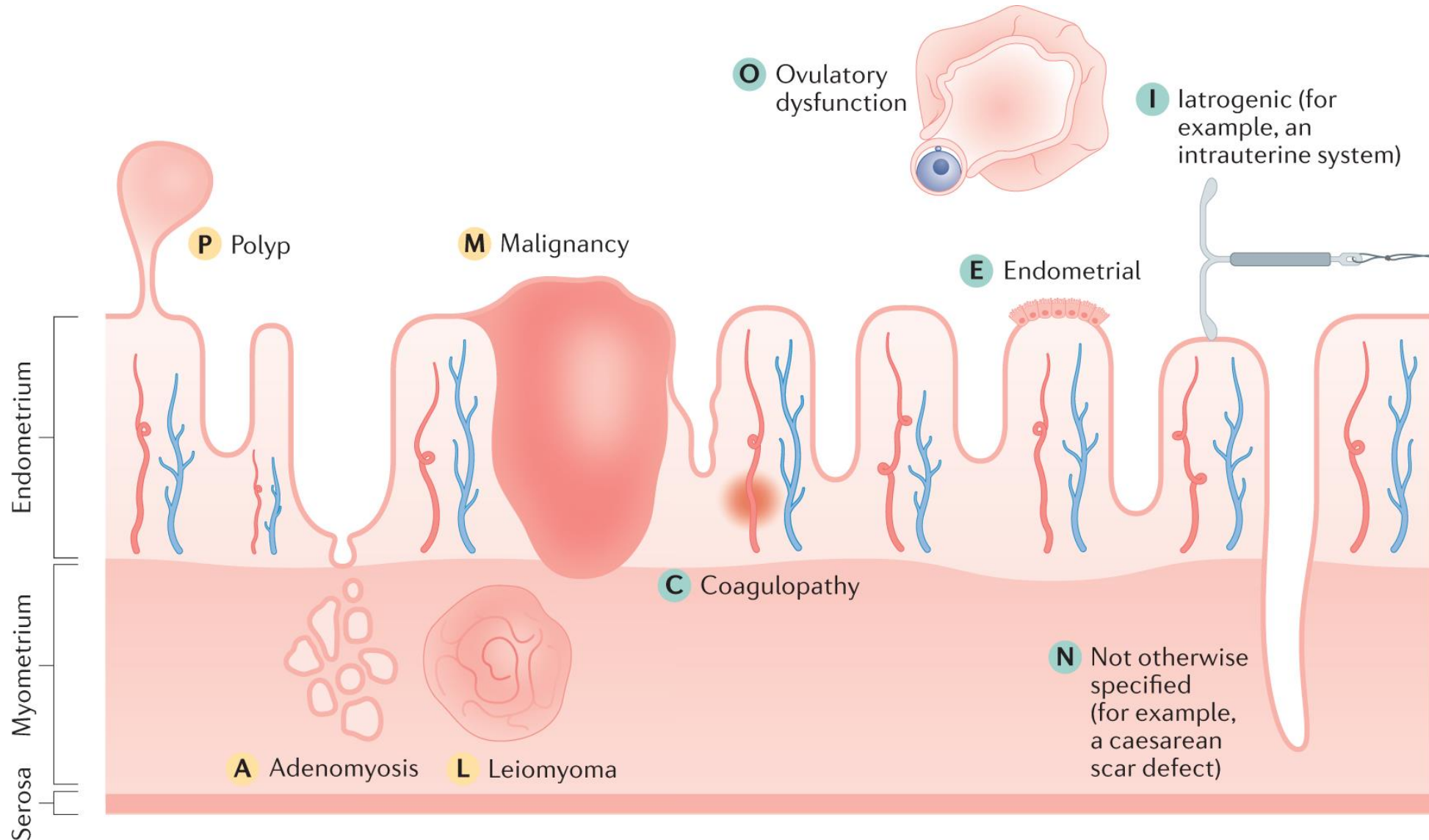


PALM COEIN

- The International Federation of Gynaecology and Obstetrics uses 'PALM COEIN' as a formal classification system for the possible underlying aetiology of abnormal uterine bleeding
 - May be a helpful

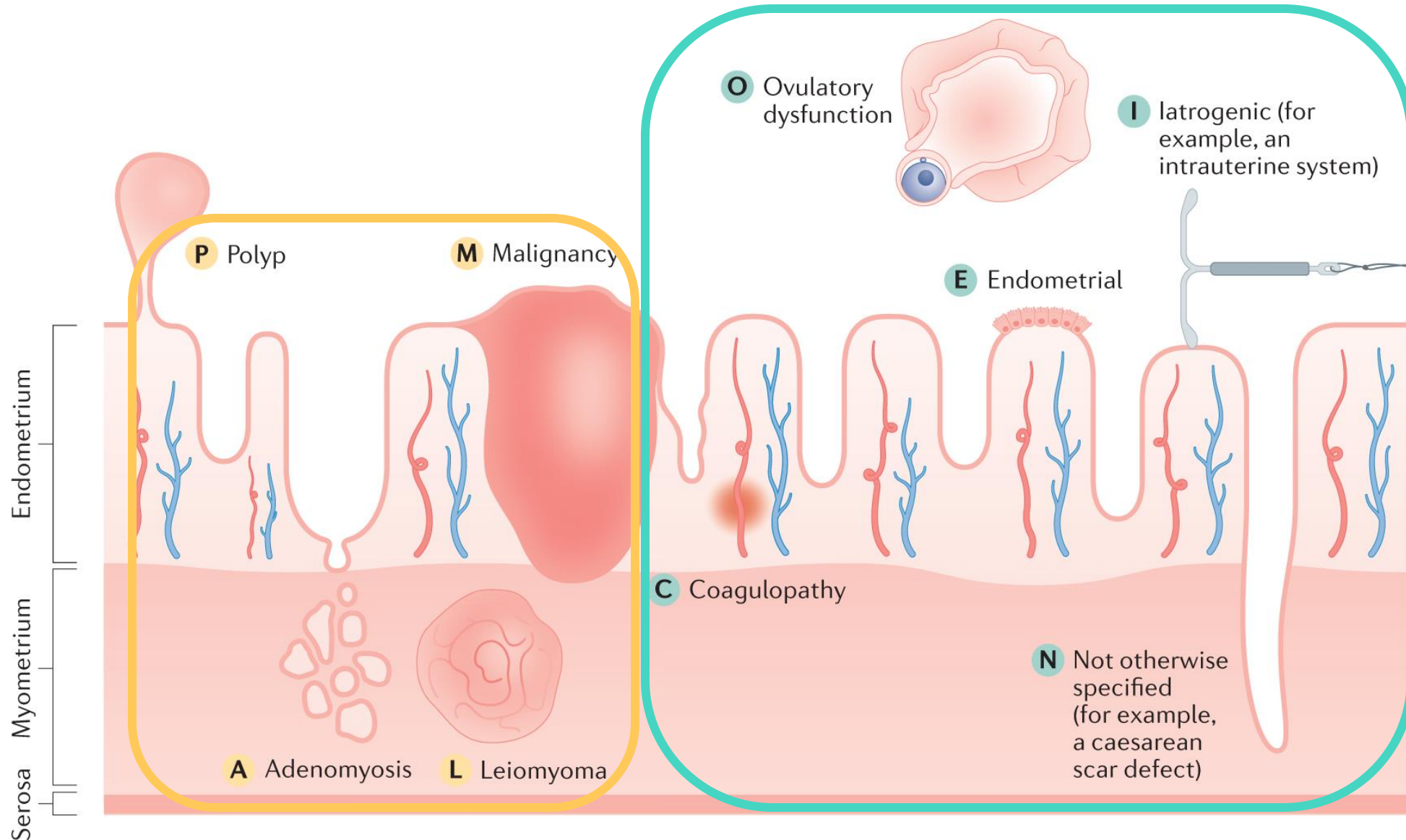


PALM COEIN

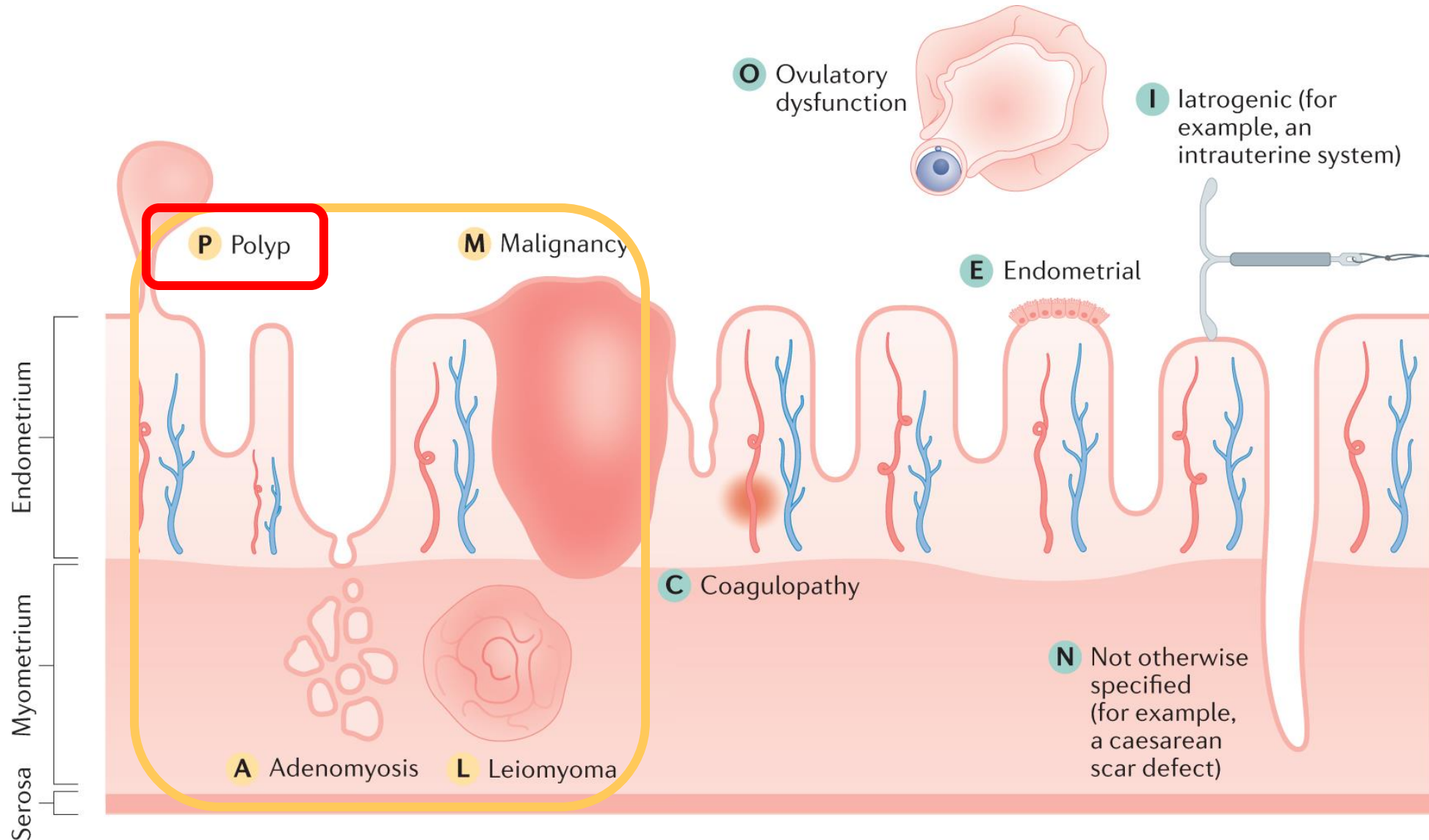


PALM COEIN

Non-structural causes

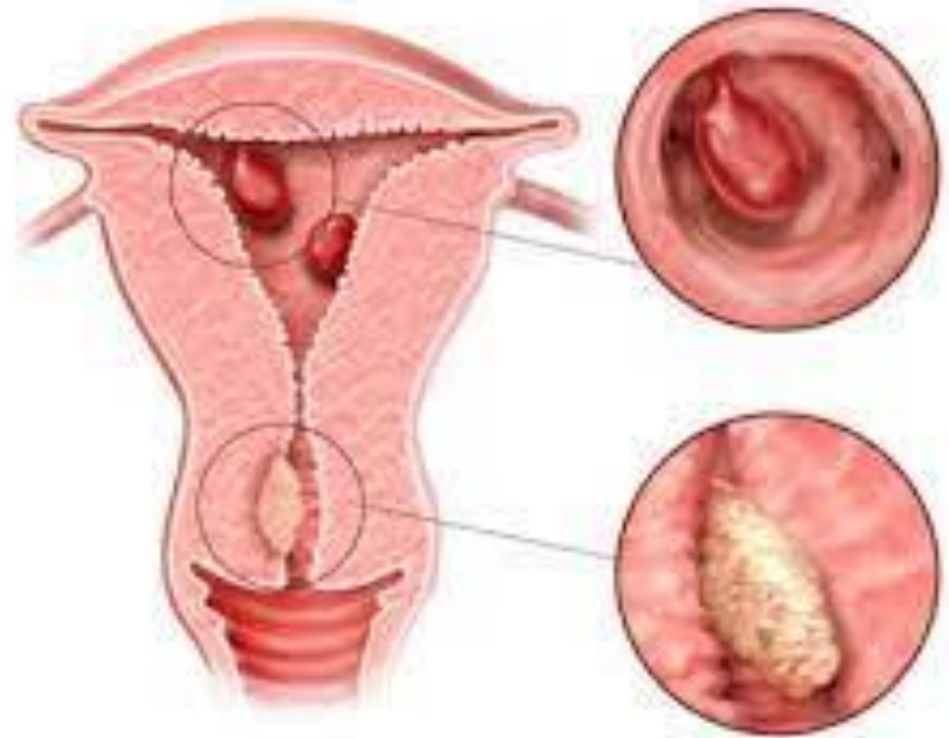


PALM COEIN



Polyps

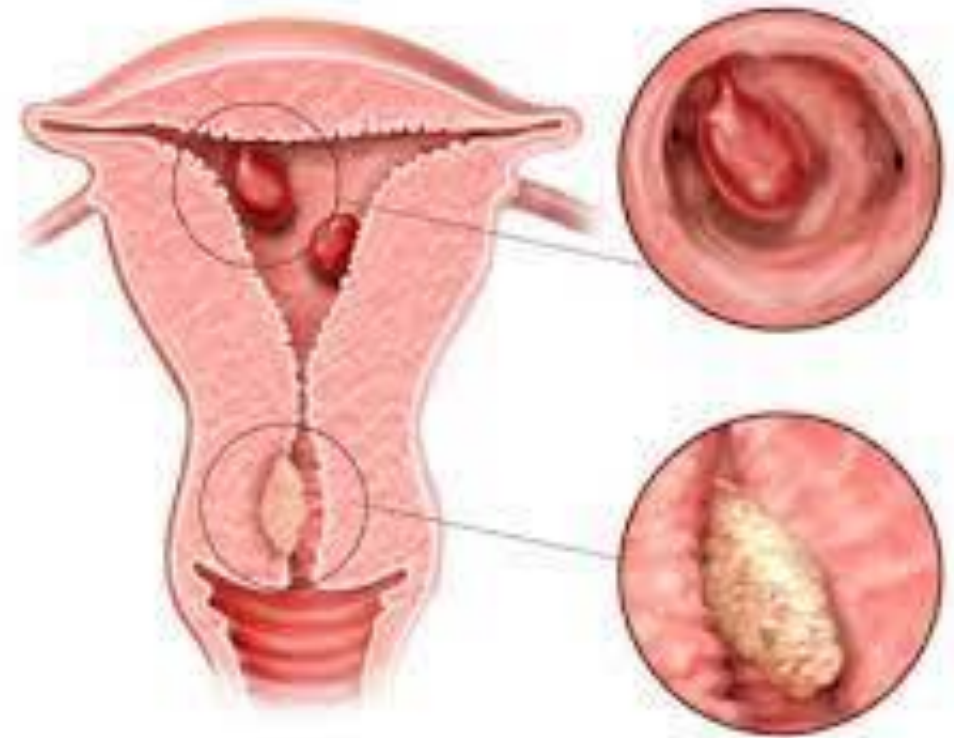
- » Localised overgrowth of endometrial glands and stroma
- » Can →
 - Prolonged and / or heavy periods
 - Intermenstrual bleeding (IMB)
 - Post-coital bleeding (PCB)
 - Postmenopausal bleeding (PMB)



Polyps

» Vast majority are benign

- 0.5 - 5% risk of malignancy
- Higher if: > 60yo; post-menopausal;
post-menopausal bleeding;
and / or tamoxifen use



Polyps: investigation and management

» Ix:

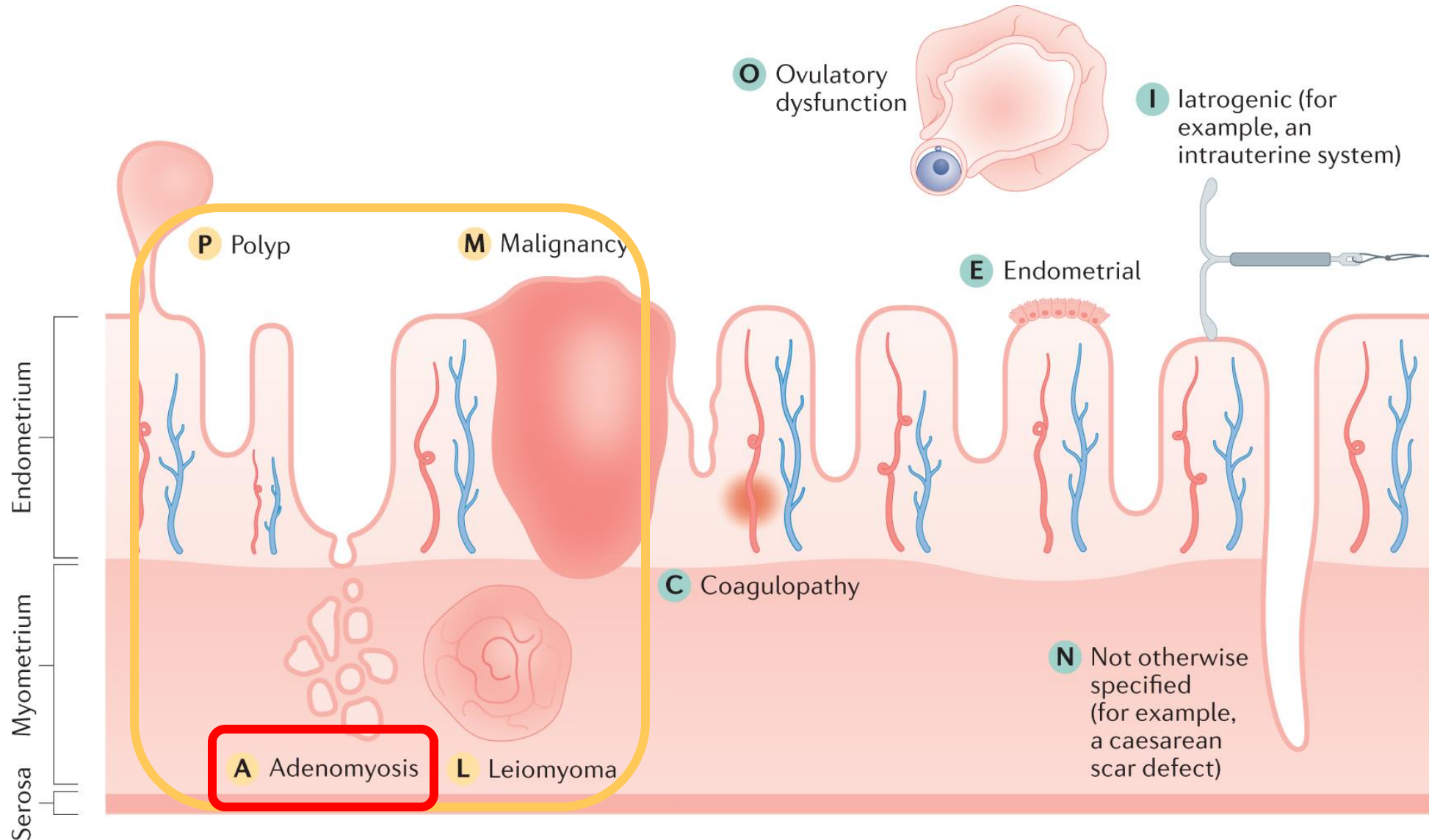
- T/V U/S

» Mx:

- If low risk of malignancy: expectant management
- If any risk factors for malignancy (> 60yo; post-menopausal; PMB; and / or tamoxifen use):
 - Hysteroscopic polypectomy
 - ± insertion of Mirena IUD

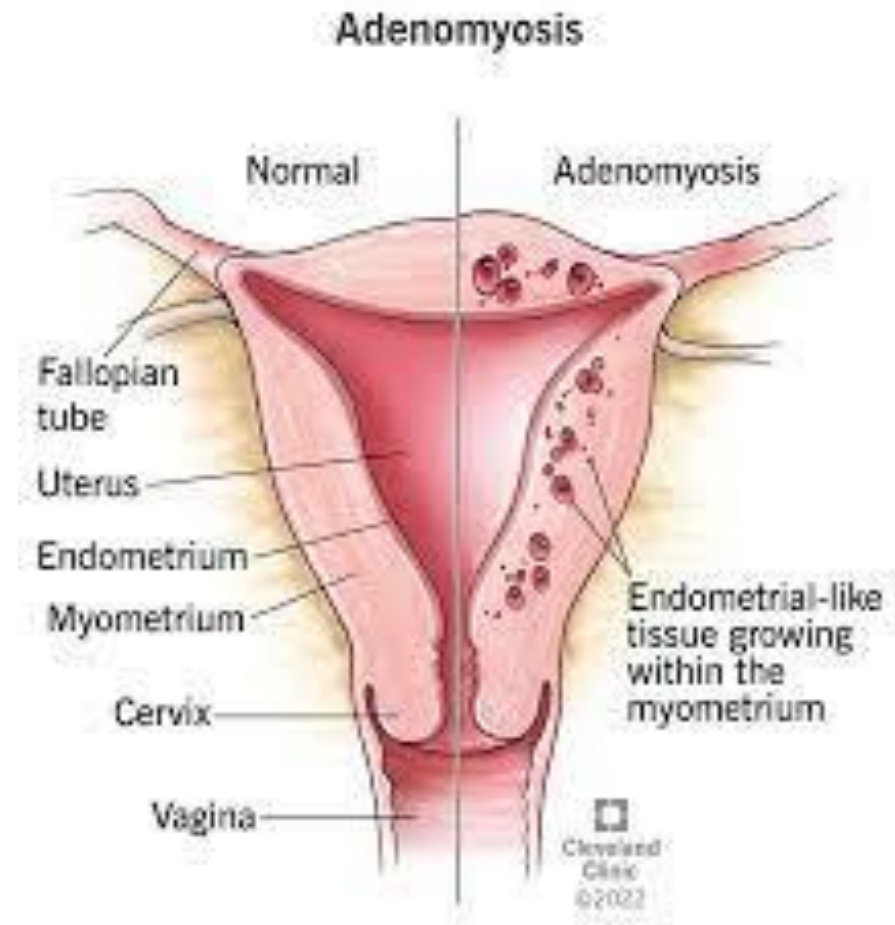


PALM COEIN



Adenomyosis

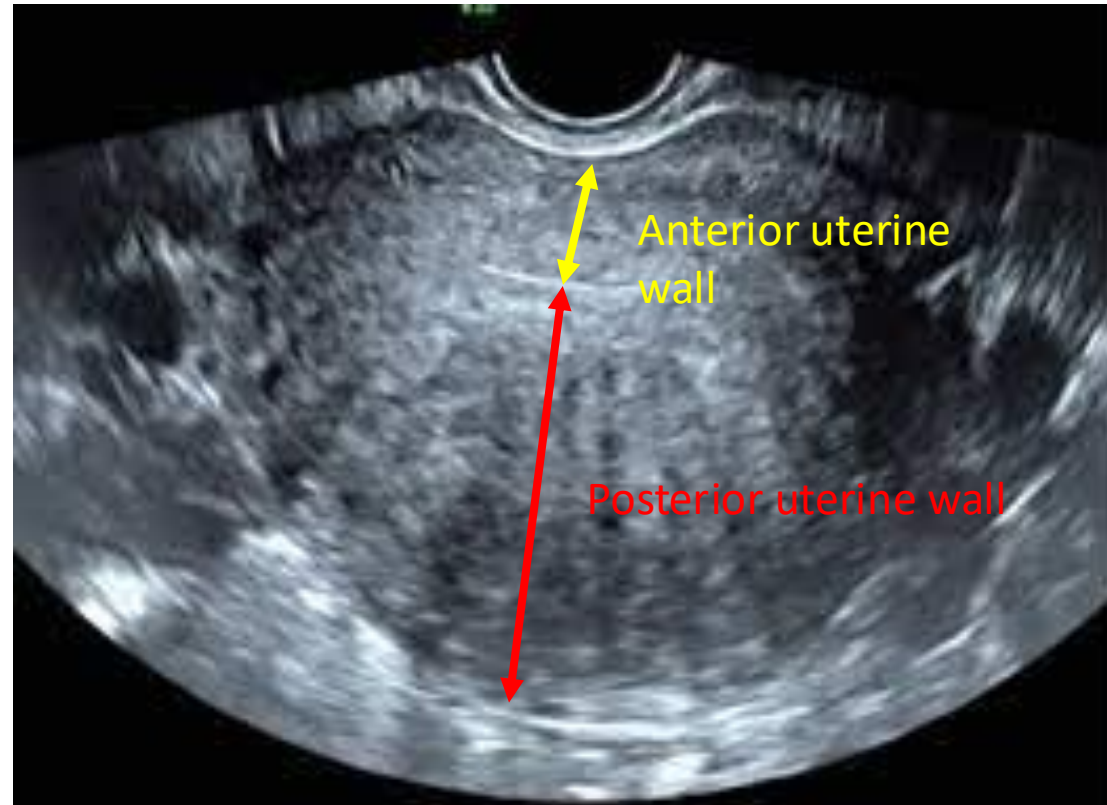
- » Benign condition in which the endometrial cells grow within the myometrium (uterine musculature) → hypertrophy of the surrounding myometrium
- » Can → prolonged and / or heavy periods
 - And also dysmenorrhoea, pressure symptoms, "swelling"



Adenomyosis: investigation

» T/V U/S:

- Bulky, 'globular' uterus
- Heterogenous myometrium
- $\pm$ asymmetrical thickening of one wall (eg. posterior uterine wall)
- 'Venetian blind' shadowing



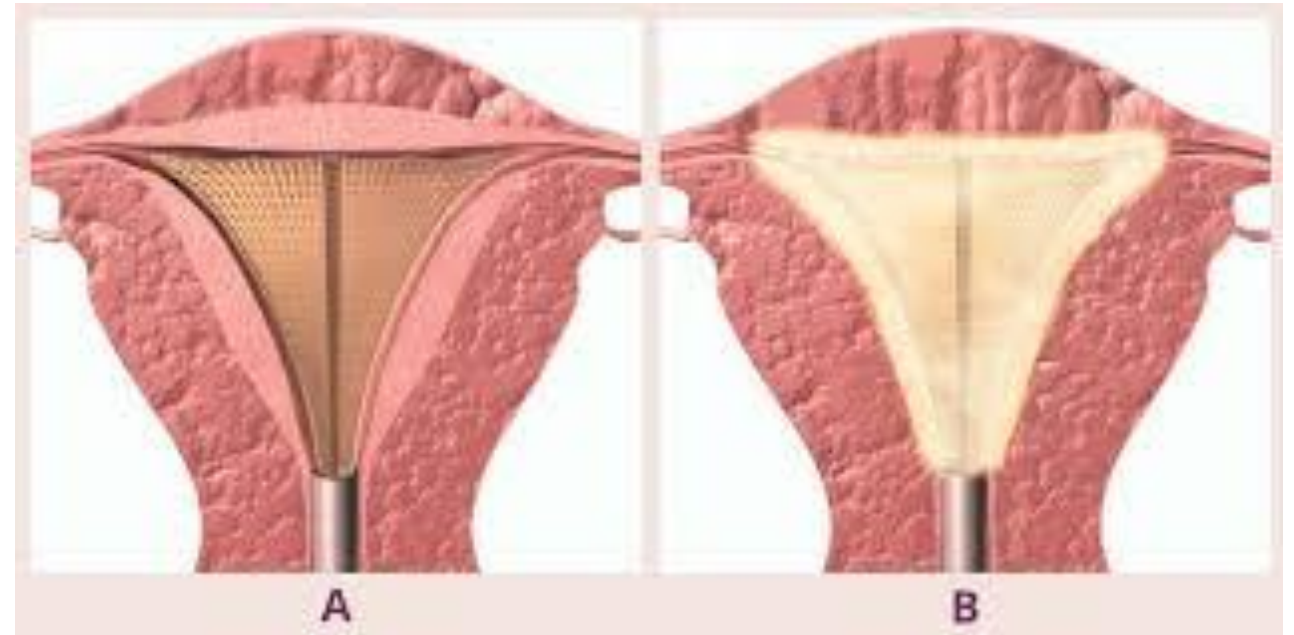
Adenomyosis: management

» Endometrial ablation

- But only 40% success rate in the context of adenomyosis
- Not appropriate if patient wants to bear children in future

» Hysterectomy

- Only definitive management



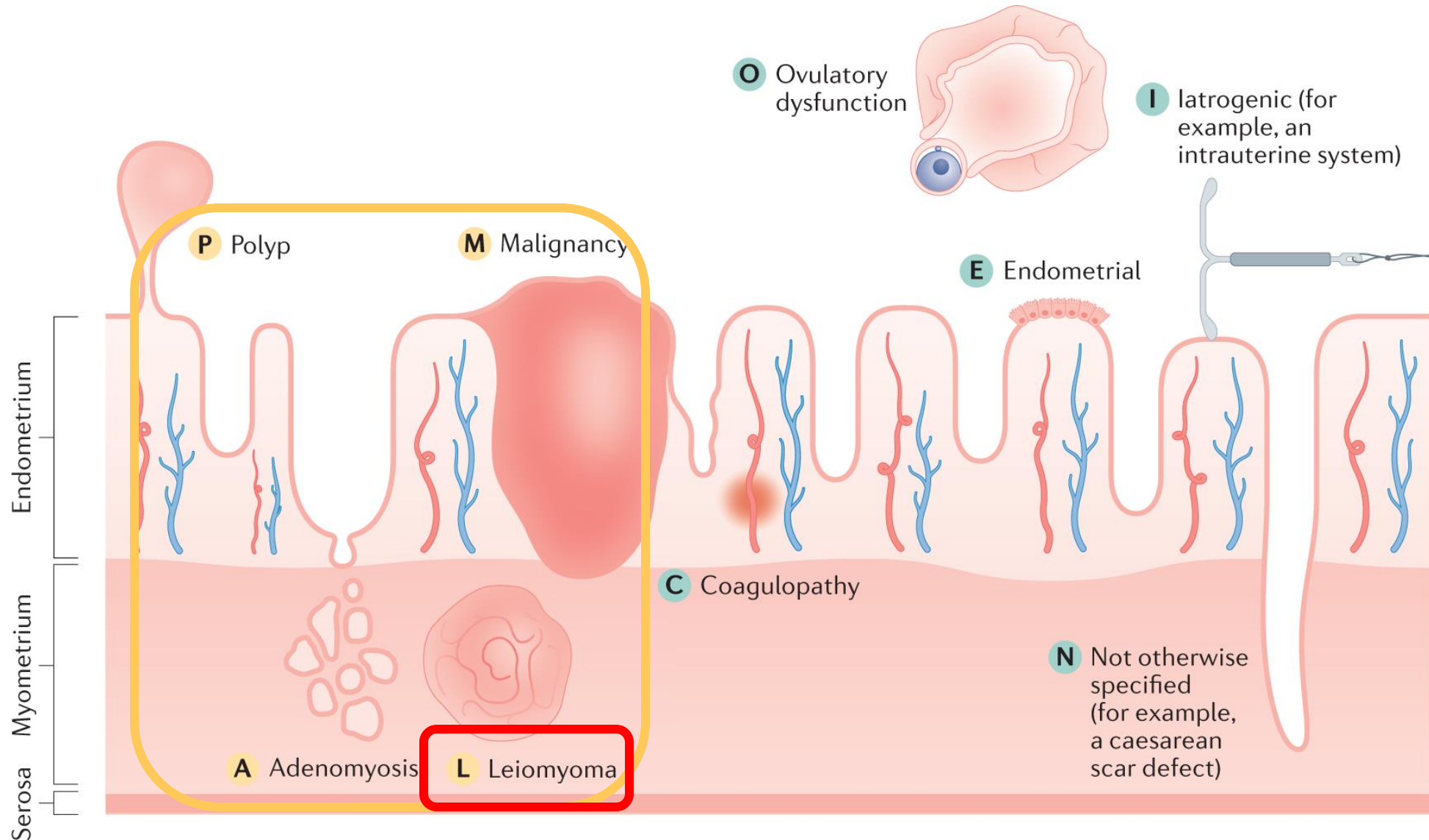
Adenomyosis: management

» If family is not yet complete:

- COCP
- Mirena IUD
- GnRH agonists
- ? off-label 'Ryeqo'
 - For temporary amelioration of symptoms



PALM COEIN



Leiomyoma = fibroids

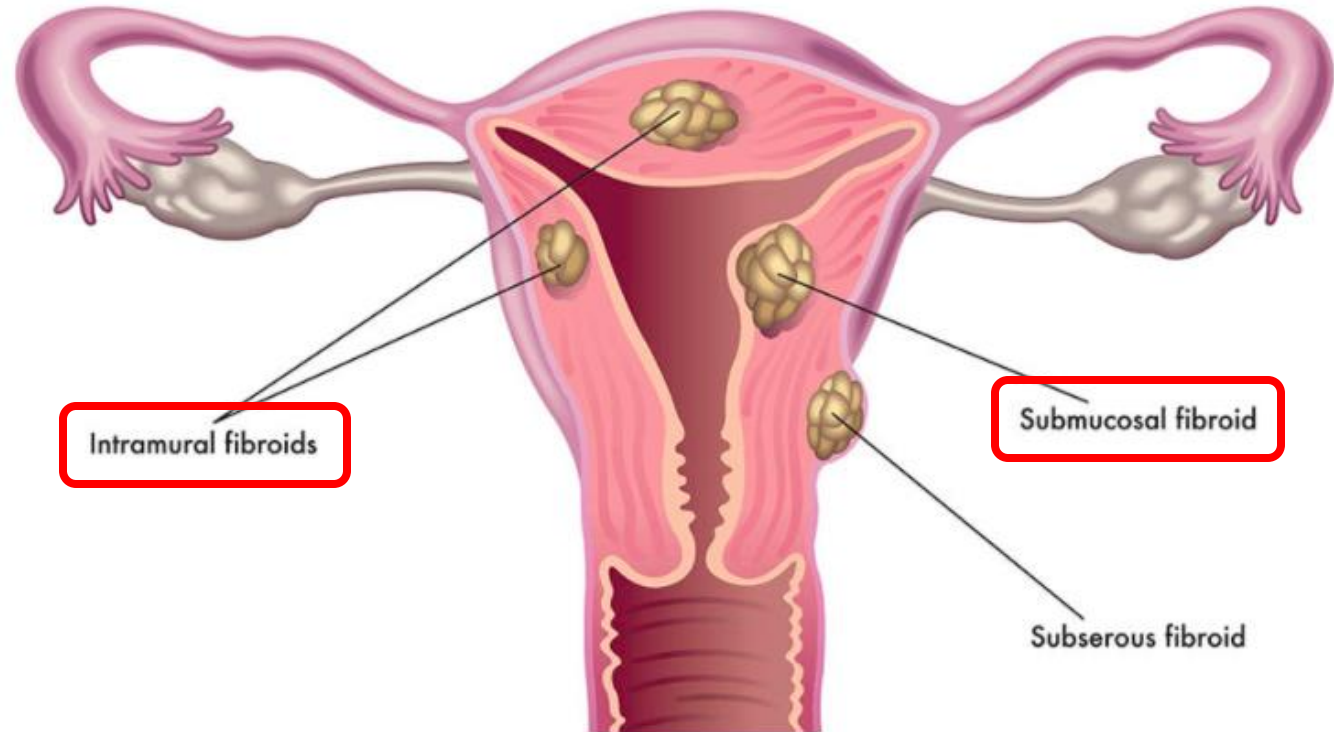
- » Benign monoclonal growths that arise from the myometrium
- » Extremely common in reproductive-age women
 - 1 in 4 women > 35yo have fibroids, half of whom are symptomatic



Leiomyoma = fibroids

» Fibroids can occur in various places in relation to the uterine cavity

- Submucosal fibroids often → HMB
- Intramural fibroids can → HMB



Leiomyoma (fibroids): investigation, management

» Ix:

- T/V U/S
- ± MRI (if suspicious features on U/S)

» Management of fibroids that are causing HMB:

- Medical
- Interventional radiology
- Minor surgical procedure
- Major surgical procedure



Leiomyoma (fibroids): first-line medical management

» Iron supplementation

- Oral iron supplementation
- Iron infusion
- Blood transfusion

» Non-hormonal tablets

- Tranexamic acid during menses

» Hormones

- COCP/Progesterone
- Mirena IUD (note submucosal fibroids or cavity distortion)

Leiomyoma (fibroids): second-line medical management

» GnRH agonists

- Eg. monthly goserelin implant "Zoladex"
- Eg. BD nafarelin nasal spray "Synarel"

» Typically used to:

- Improve iron stores pre-op (95% of women are amenorrhoeic)
- Shrink fibroids pre-op (by 40%) → less invasive operation
- Avoid surgery altogether

Leiomyoma (fibroids): GnRH agonists

» Pros:

- 95% of women amenorrhoeic
- 40% shrinkage of fibroid uterus

» Cons:

- Hypo-estrogenic side-effects
- Maximum course is 6 / 12 months

» Offer add-back estrogen (eg. 'tibolone') to:

- Mitigate side-effects
- Lengthen course to 12 months

Leiomyoma (fibroids): GnRH antagonist, 'Ryeqo'

» Polypill combination of:

- GnRh antagonist (relugolix)
- Estrogen (estradiol)
- Progesterone (norethisterone)

in a single daily tablet

» First *oral* formulation that both shrinks multi-fibroid uteri *and* reduces HMB

Leiomyoma (fibroids): GnRH antagonist, 'Ryeqo'

» Pros:

- Single oral tablet daily
- Can be taken until menopause
- Bone mineral density maintained
- Lightens periods by 85%
- Reversible contraception

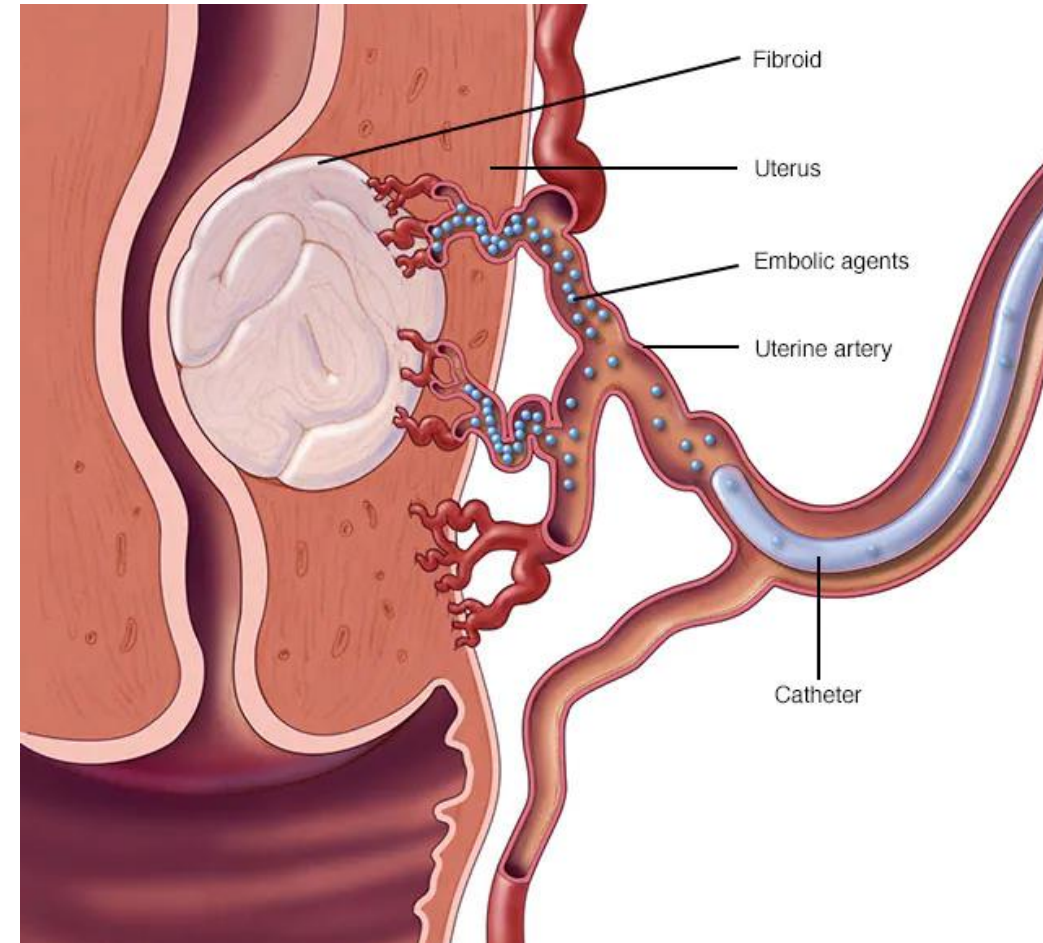
Leiomyoma (fibroids): GnRH antagonist, 'Ryeqo'

» Cons:

- TGA approved for fibroids but not on the PBS → \$135 / month
- DEXA scan needed within first year and at 2 years
- Long-term studies in progress

Leiomyoma (fibroids): interventional radiology

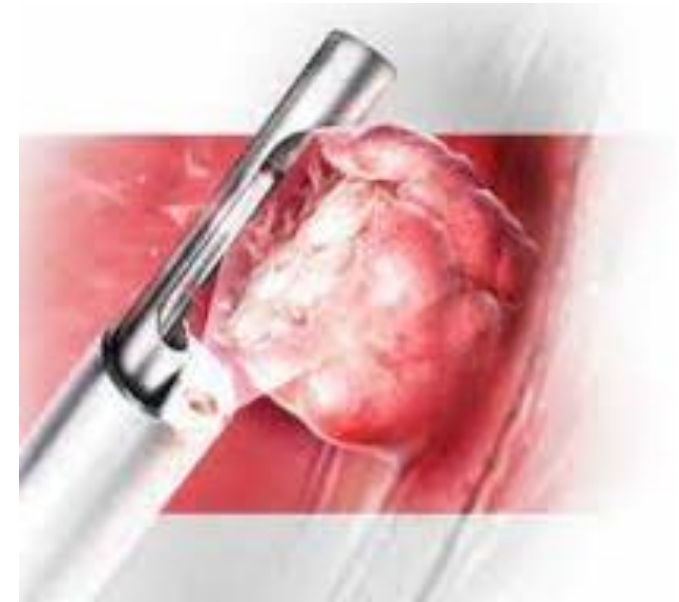
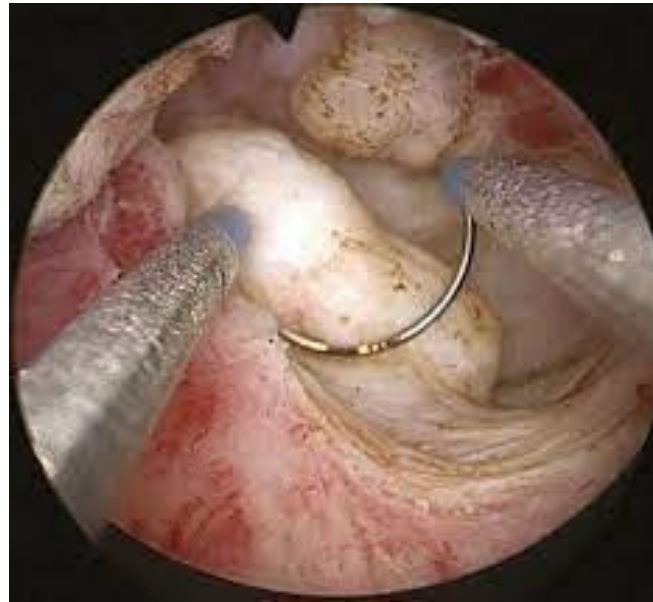
- » Uterine artery embolization
- » Now easy to access – IR department at WH can provide this service
- » Future fertility: relative contraindication
 - evidence on UAE and fertility is limited and inconsistent, but several studies show higher miscarriage rates than after myomectomy



Leiomyoma (fibroids): minor surgical procedure

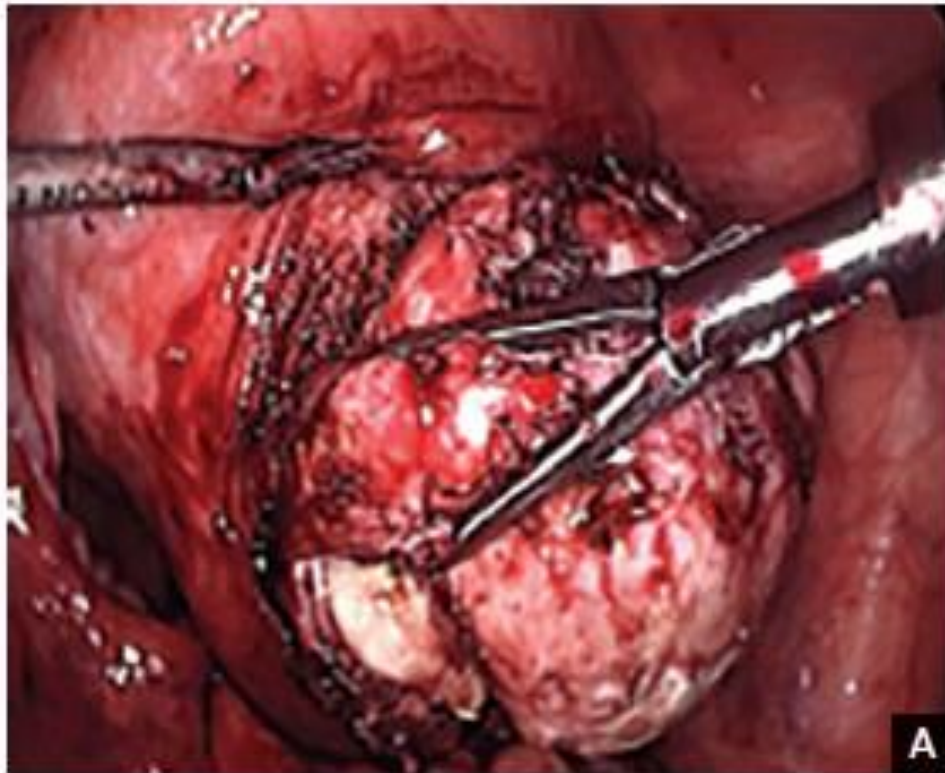
» Hysteroscopic myomectomy

- Day procedure, under GA
- $\pm$ endometrial ablation (if family complete)
- $\pm$ insertion of Mirena IUD



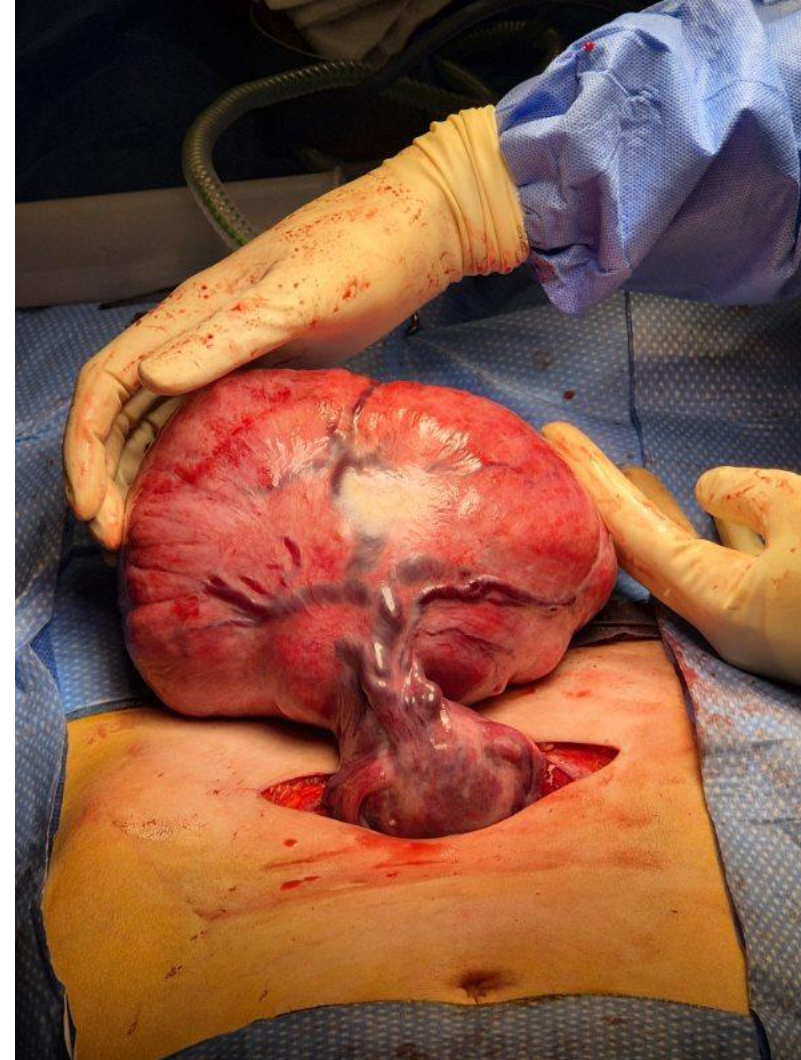
Leiomyoma (fibroids): major surgical procedure

» Laparoscopic myomectomy

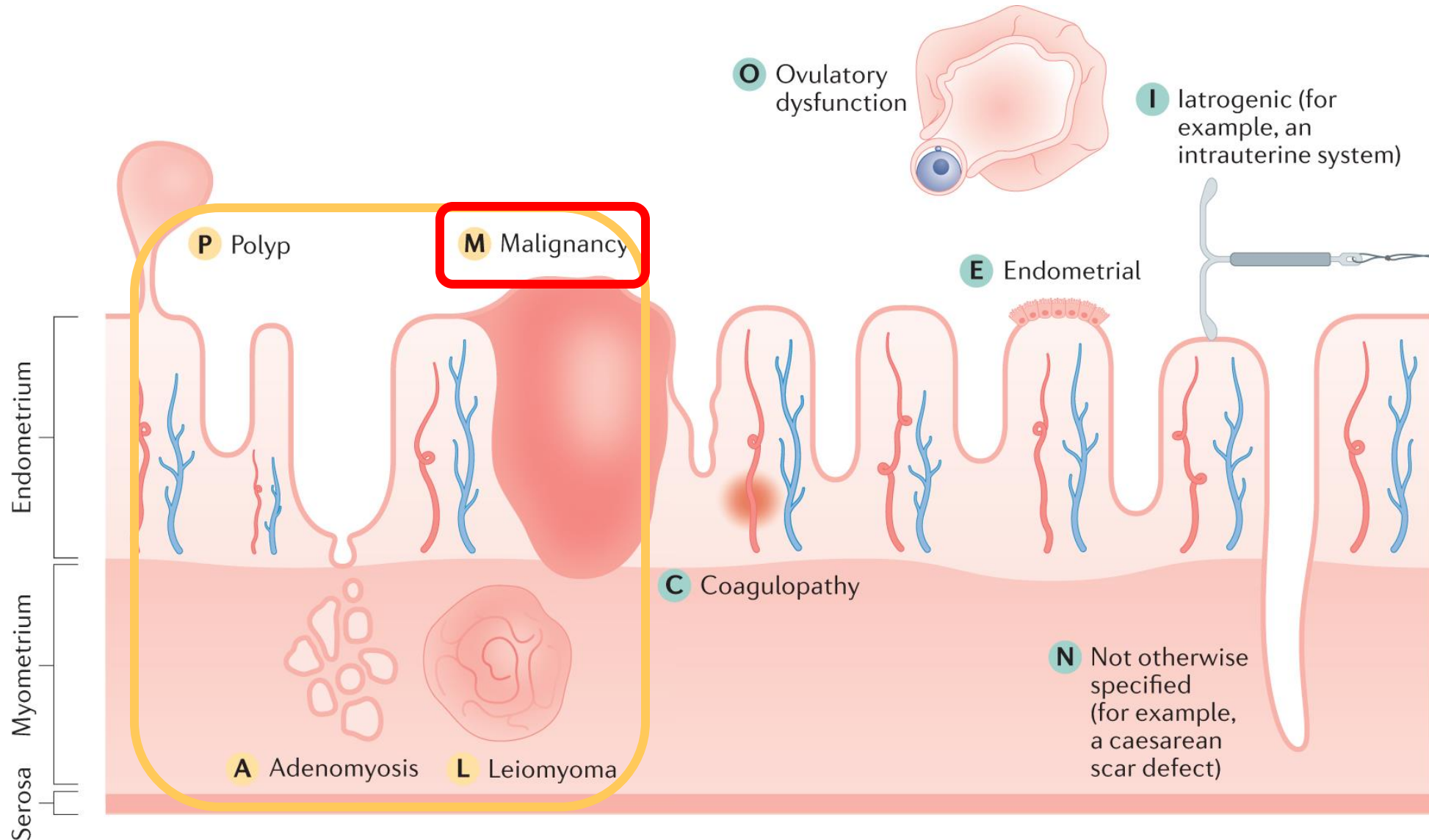


Leiomyoma (fibroids): major surgical procedure

- » Open myomectomy
- » Hysterectomy



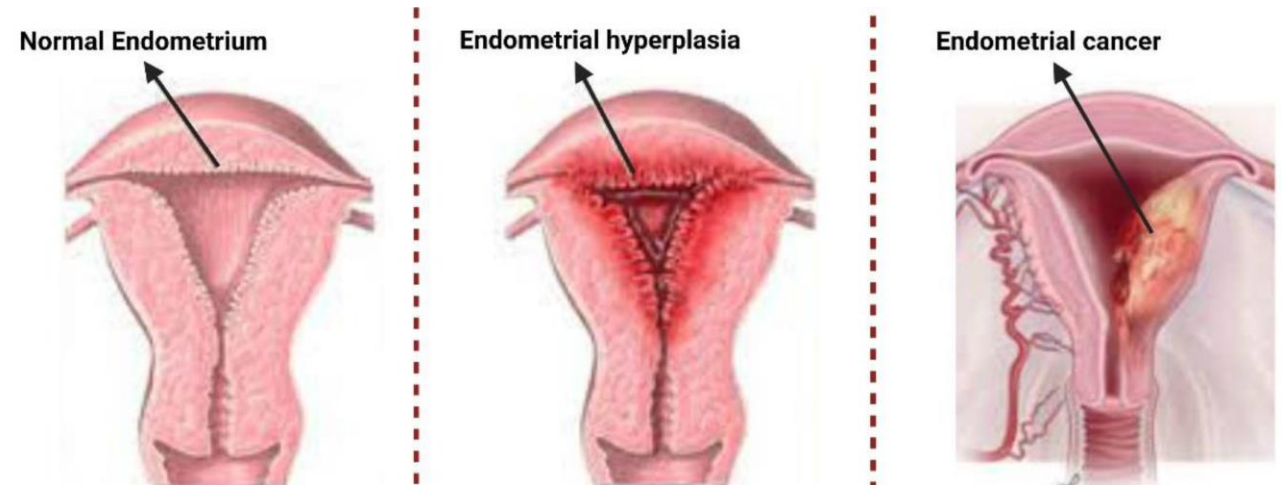
PALM COEIN



Malignancy: endometrial hyperplasia / cancer

» Endometrial hyperplasia (E.H.) = a proliferation of endometrial glands

- E.H. *with atypia* is considered an immediate precursor to cancer



Malignancy: endometrial hyperplasia / Ca risk factors

» Unopposed excess oestrogen

- Eg. estrogen-containing hormone replacement therapy without any progesterone to protect the endometrium
- Eg. increasing BMI and adipose tissue

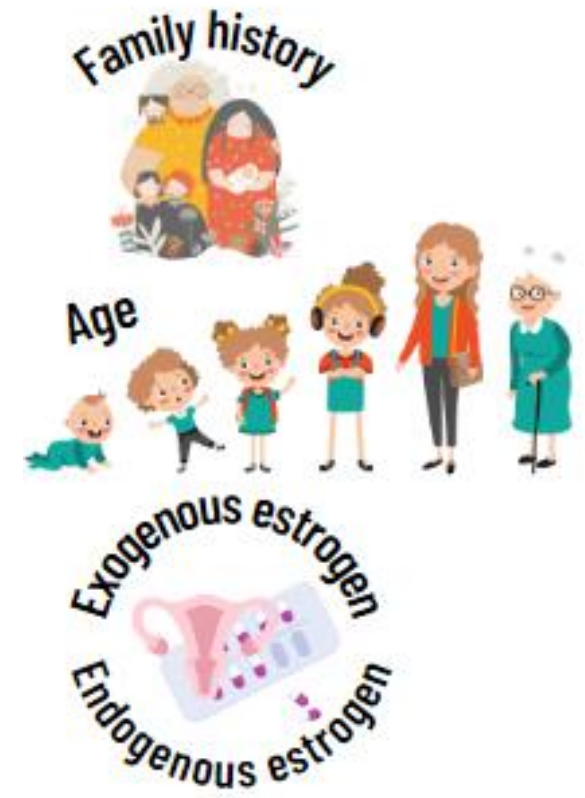
→ higher circulating estrogen

→ thickens endometrium

→ endometrial hyperplasia and / or cancer

» Lynch syndrome (aka. HNPCC)

» PCOS



Malignancy: endometrial hyperplasia / cancer Ix

» T/V U/S

- E.H. → cystic spaces in the endometrium, thickened endometrium
- Endometrial Ca → thickened endometrium ± endometrial mass

» Endometrial biopsy

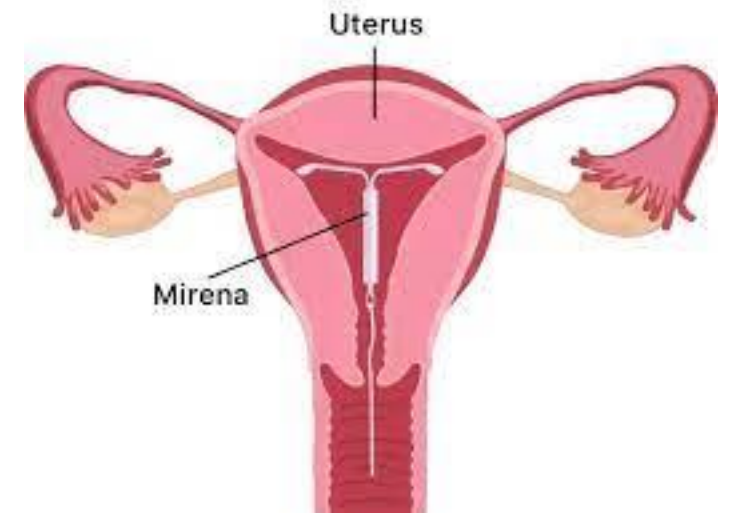
- Pipelle biopsy (in clinic, while patient is awake)
- Hysteroscopy and curettage (while patient is asleep)



Malignancy: endometrial hyperplasia Rx

» E.H. without atypia:

- High dose progesterone (Mirena IUD / oral Provera)
- Six monthly curette + change of Mirena until E.H. regresses (two benign pathology results)

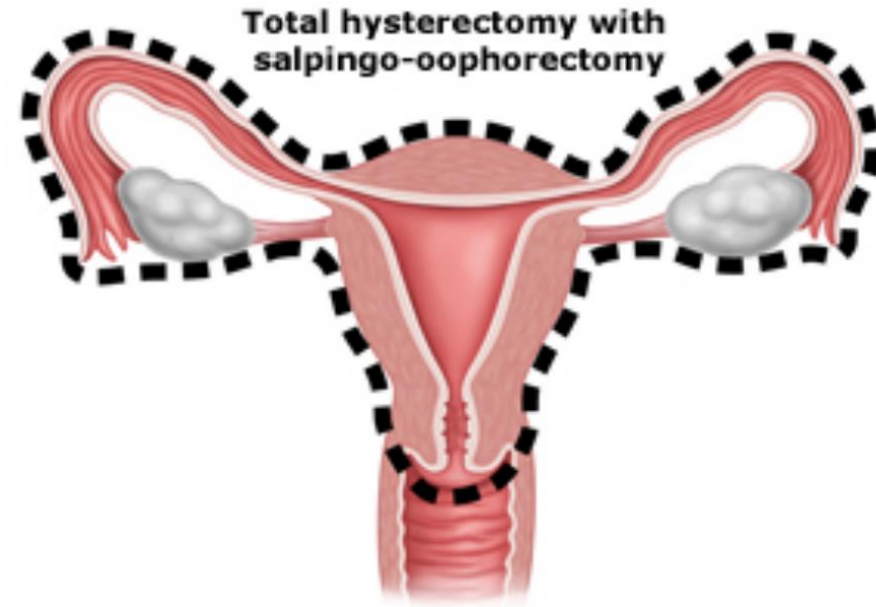


» E.H. with atypia: hysterectomy

- If fertility desired then above with hysterectomy once family complete

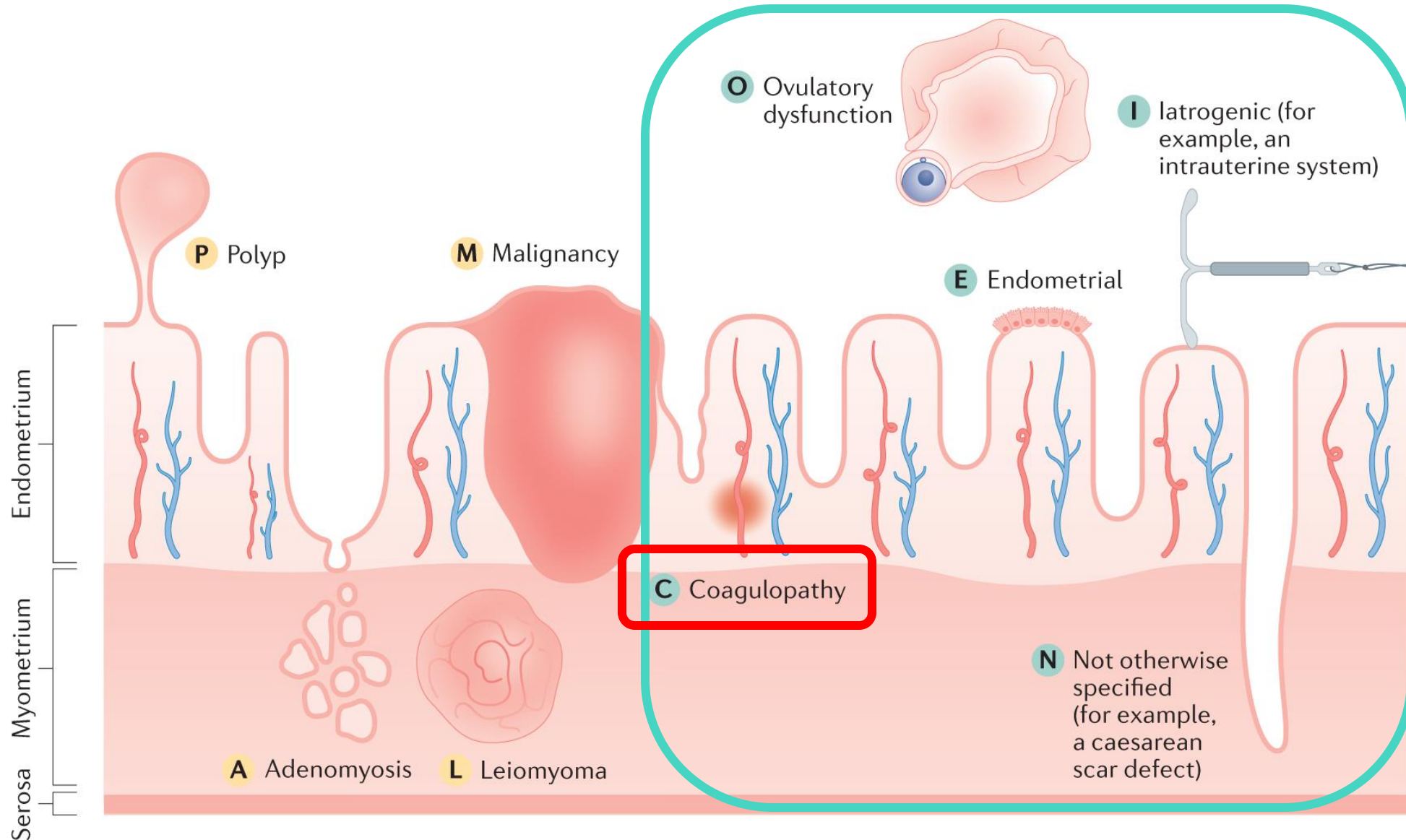
Malignancy: endometrial cancer Rx

- » Referral to gynaec-oncologist (eg. Western Health GynOnc Unit)
- » Radical Hysterectomy, bilateral salpingo-oophorectomy
- » $\pm$ radiotherapy



PALM COEIN

Non-structural causes



Coagulopathy: hereditary coagulopathies

- » Eg. von Willebrand disease
- » Hx: ISTH-BAT / self-administered

Self-BAT – validated tool

- ? bruise easily
- ? epistaxis lasting 10 mins
- ? bleeding excessively dental procedures
- ? family history

* "EASY BRUISING"



* ECCHYMOSES



* HEMARTHROSIS



* DEEP TISSUE HEMATOMAS



* POSTERIOR EPISTAXIS



* GI BLEEDING



* URINARY BLEEDING



* PERSISTENT BLEEDING AFTER SURGICAL PROCEDURES



* INTRACEREBRAL HEMORRHAGE
→ STROKE / ↑ INTRACRAN



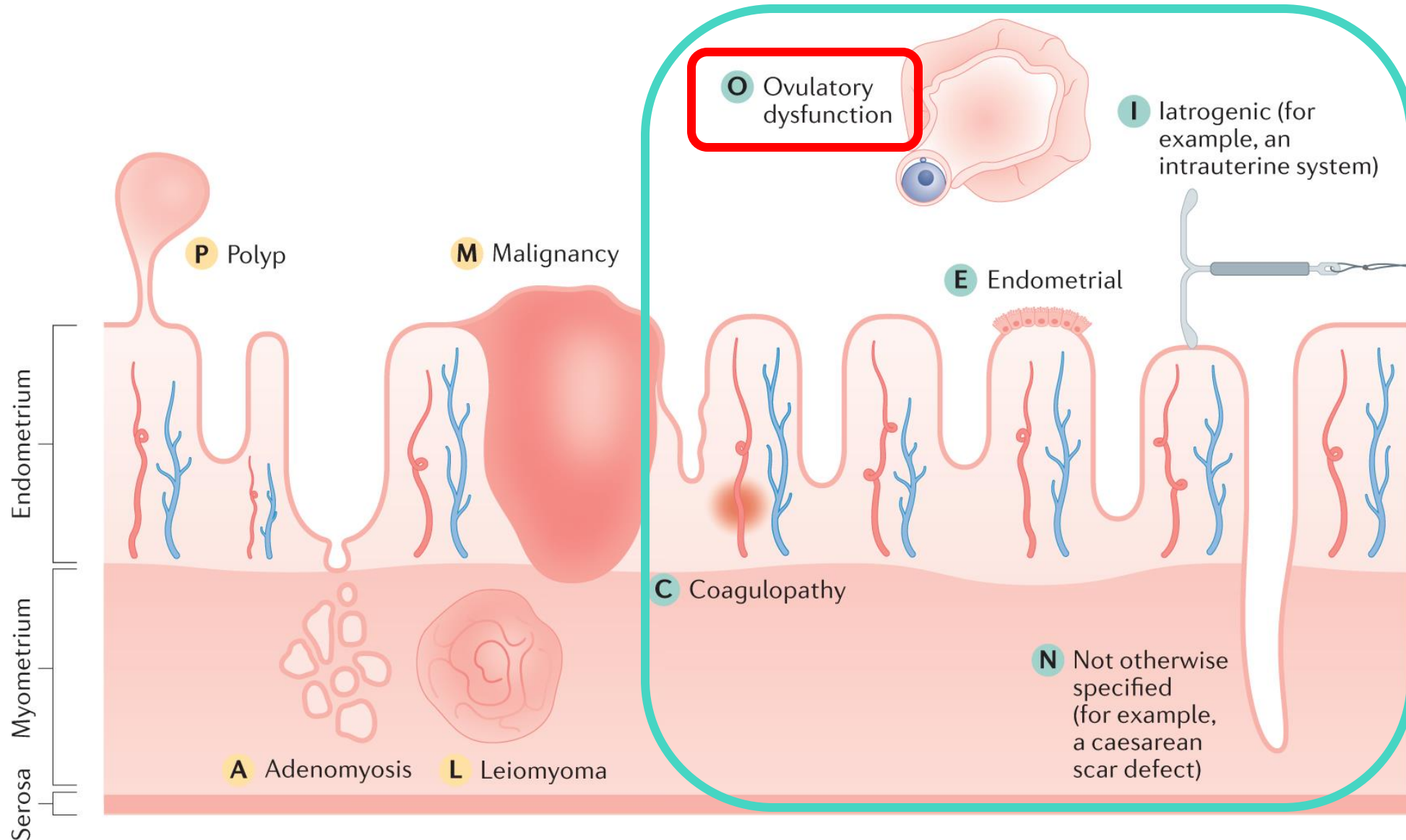
Coagulopathy: acquired coagulopathies

- Thrombocytopaenia
 - Idiopathic thrombocytopaenia purpura (ITP)
 - Thrombotic thrombocytopaenia purpura (TTP)
 - Hypersplenism
 - Chronic kidney disease
- Acute leukaemia
- Anti-coagulant use
- Advanced liver disease

But: unlikely that heavy bleeding would be the presenting symptom of any of the above

PALM COEIN

Non-structural causes



Ovulatory dysfunction: anovulatory cycles

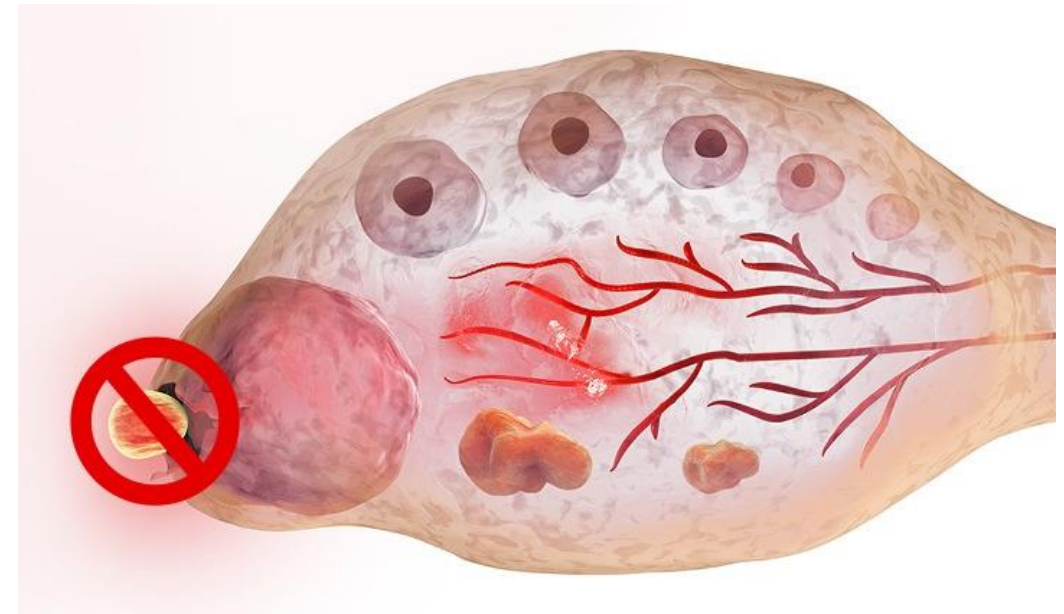
» In teenagers

- COCP to regulate cycle, lighten periods

» Peri-menopausal women

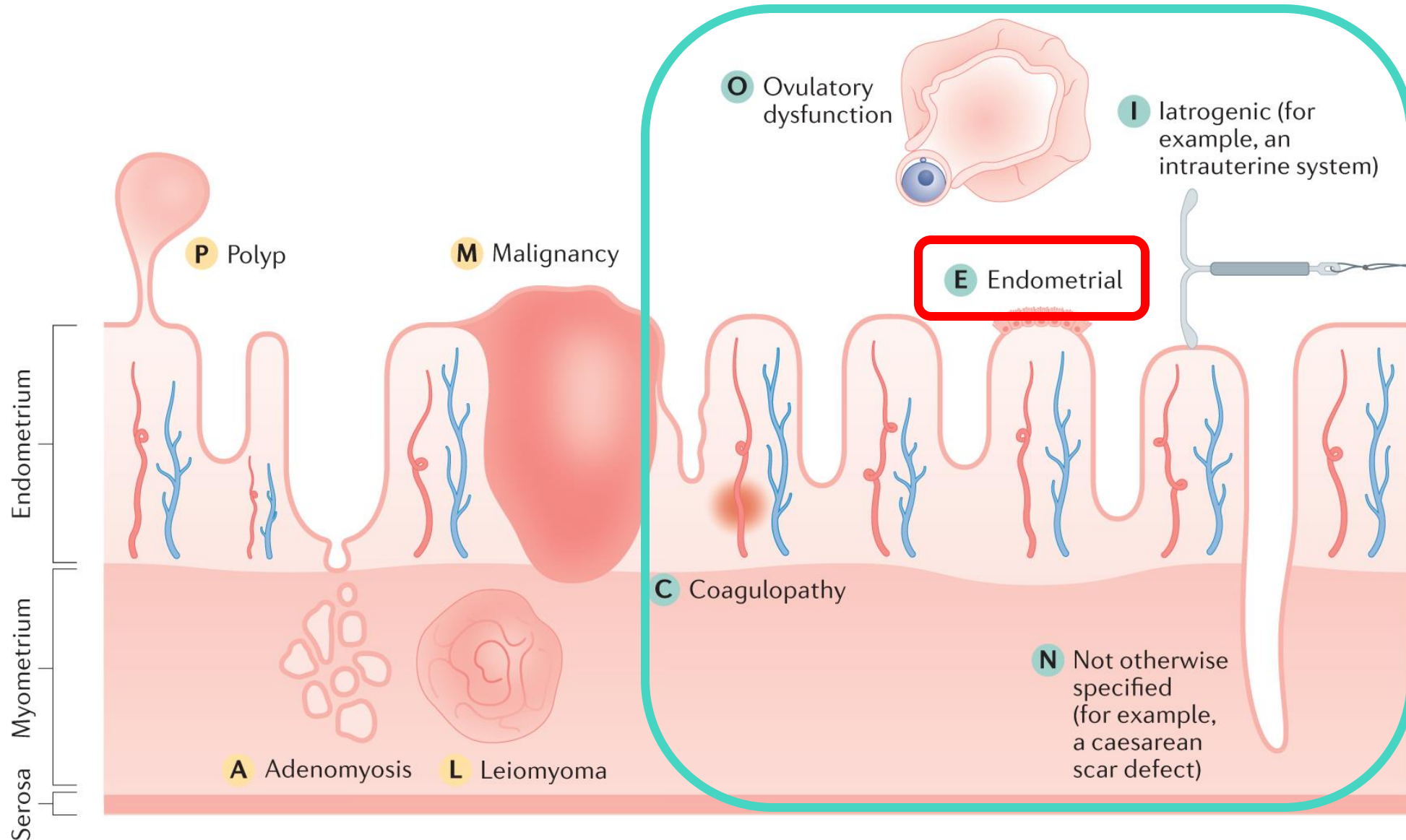
- T/V U/S to exclude structural causes requiring management
- Supportive management
- Luteal phase norethisterone
- TXA during menses

» Thyroid disorders



PALM COEIN

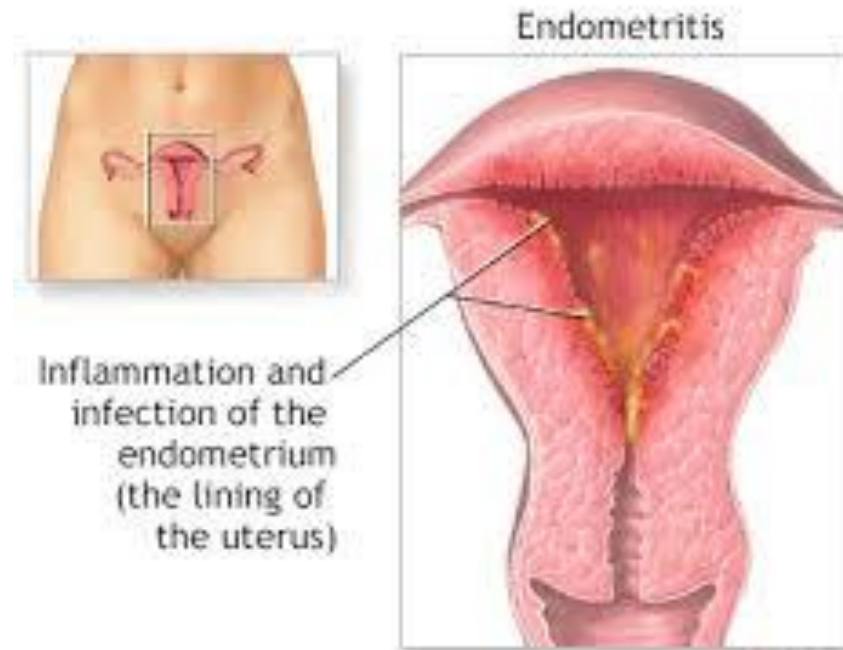
Non-structural causes



'Endometrial'

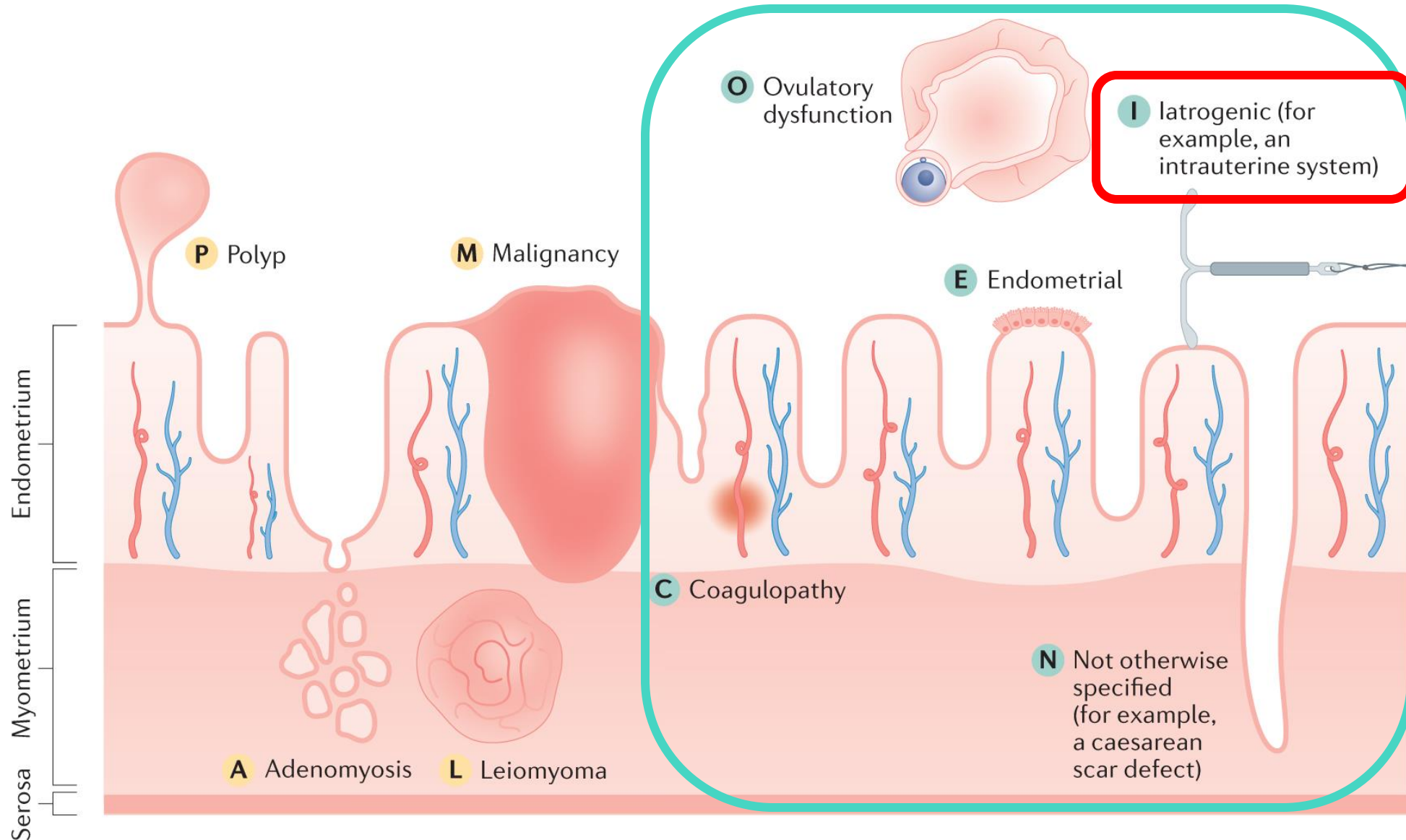
» Diagnoses of exclusion

- Eg. chronic endometritis



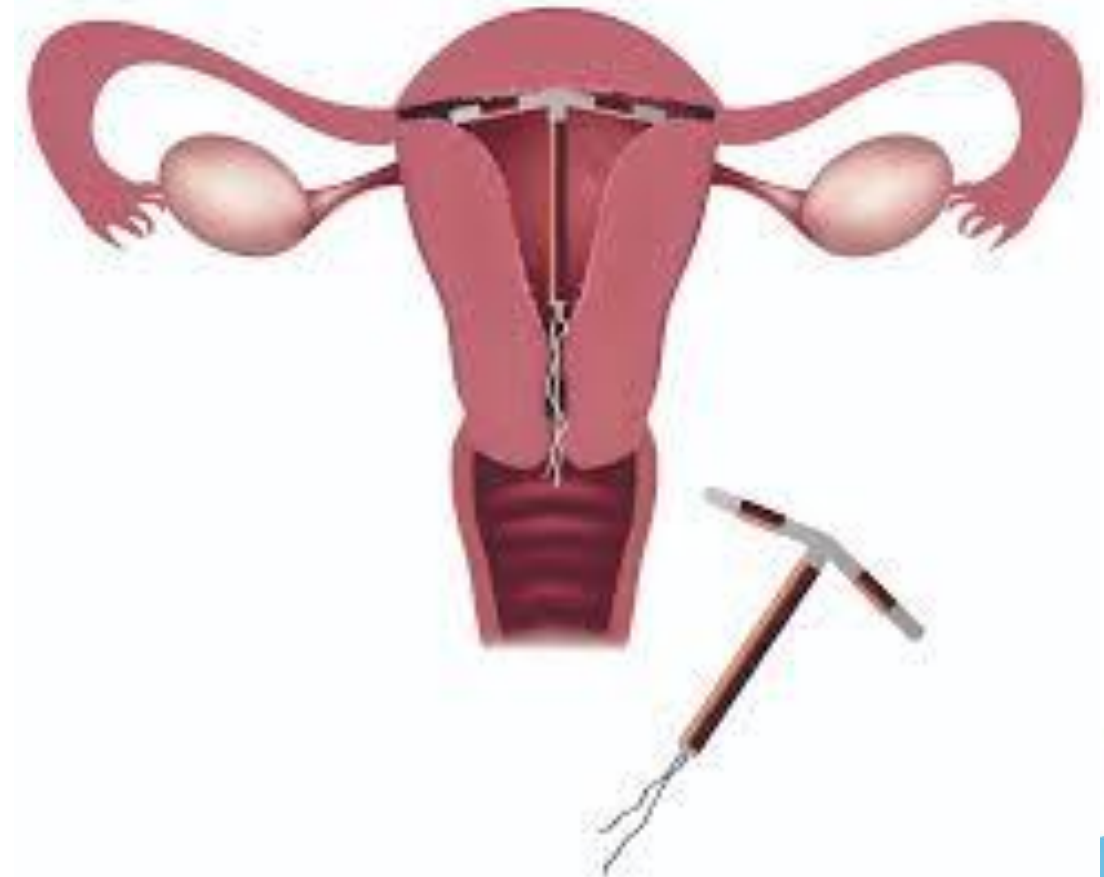
PALM COEIN

Non-structural causes



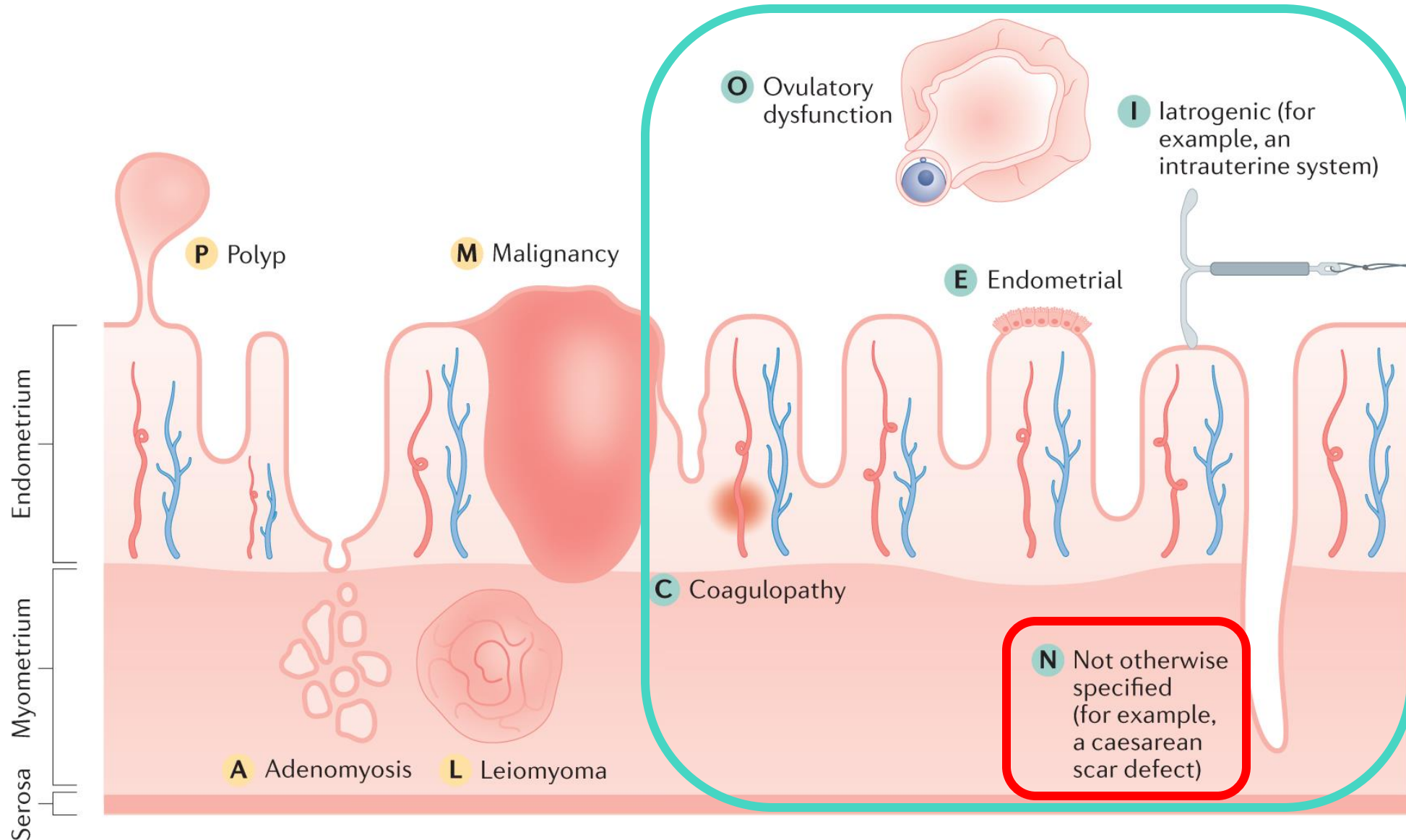
Iatrogenic

- » Copper IUD
- » Anti-coagulant medication(s)



PALM COEIN

Non-structural causes



Not otherwise specified

- » Arterio-venous malformations
- » Caesarean scar defect – this would cause abnormal bleeding but not heavy bleeding

Heavy menstrual bleeding: pragmatic approach

» If Sxs since menarche:

- ? hereditary coagulopathy

» **If Sxs have developed over time, patient in reproductive years:**

- ? **structural uterine cause: fibroids, polyp(s) and/or adenomyosis**
- ? acquired coagulopathy
- ? hypothyroidism

» If Sxs have developed over time and patient is in or beyond reproductive years:

- ? pre-malignant / malignant process



Western Health



Thank you!

Measuring outcomes for today

To obtain Measuring Outcomes hours for this session use the RACGP's Measuring Outcomes Tool.

Follow these five steps:

1. Log-in to myCPD
2. At very top of myCPD, click on 'Log'
3. From drop-down menu, click on 'Measuring Outcomes Tool'
4. Complete the form
5. Once you have completed the form, go to top of form and click 'Submit'



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After this session you will receive:

1 Slides, resources and the recording of this session within the week

2 RACGP CPD hours will be uploaded within 14 days.

3 Attendance certificate will be received within 4-6 weeks.

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- **Past education sessions can be found here:**
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We welcome your feedback.
Let us know if you got what
you needed from this session.

