Gynecologic Emergencies

Pelvic Inflammatory Disease

Breakdown of normal host barriers (cervical mucous, lysozymes, local IgA, cervix) allows ascension of pathogens.

Breakdown is most commonly secondary to menstruation.

80% of cases are secondary to

N. gonorrhea and chlamydia

Risk factors?

P.I.D.

Classic picture is a sexually active woman with bilateral abdominal pain, vaginal discharge, fever and constitutional symptoms.

Exam reveals CMT, discharge and bilateral adnexal tenderness.

What is the differential for the same presentation with UNI-lateral adnexal tenderness?

Ectopic
Tubo-ovarian abscess
Adnexal torsion
Appendicitis
Ovarian Cyst

Diagnostic Studies:

- CBC
- Endocervical specimens
- B-Hcg
- Ultrasound
- Laparoscopy

Diagnosing PID

Definitively diagnosed by:

a. confirmation of fluid filled tubes or TOA
b. histopathologic confirmation of endometritis
c. PID findings on laparoscopy

Clinically diagnosed by:

a. lower abd. tenderness, CMT, adnexal tenderness with temp, vaginal d/c, leukocytosis, + GC or chlamydia swab

Treatment: All regimens cover GC, chlamydia, anaerobes, G – rods, strep

Who warrants inpatient treatment?

Outpt: Ceftriaxone +doxy X 14d or azithro

Inpt: Cefoxitin/Cefotetan + doxy or
Clinda + gent

Why do we care about PID?

- It is a risk factor for future ectopic, infertility and chronic pelvic pain
- Its complications include TOA, Fitz-Hugh-Curtis syndrome and obstetric complications

Cervicitis

- May be GC, Chlamydia or trich
- Clinical diagnosis (pelvic exam and wet prep)
- Think of this as on a spectrum with PID
- Tx: Flagyl if trichomonads on wet prep or with Ceftriaxone + Azithro or Doxy

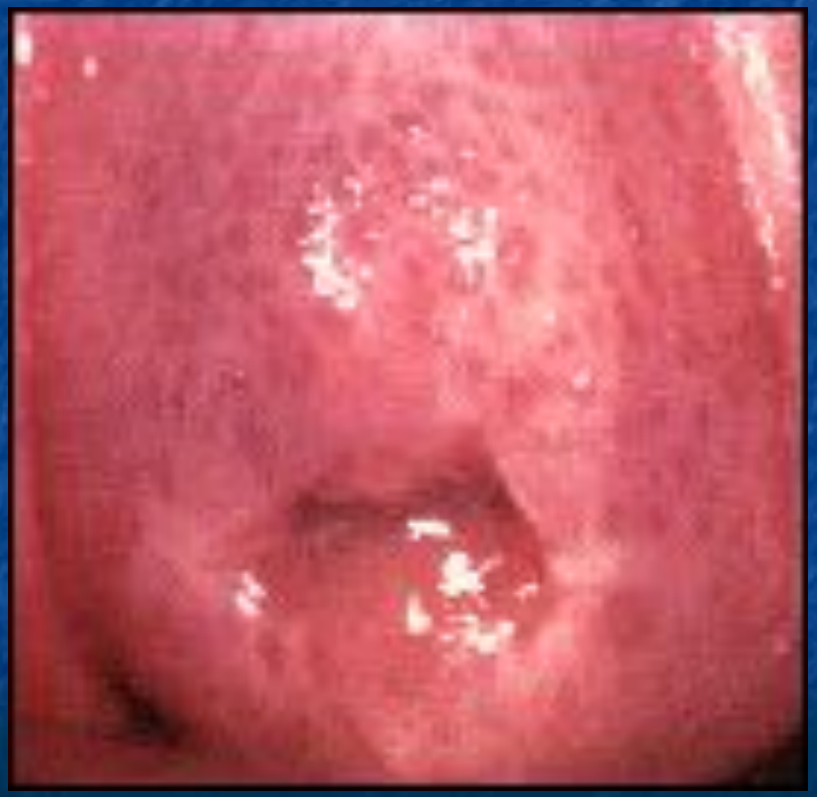
Vaginal Discharge and Vulvovaginosis

Differentiating between trichomoniasis, bacterial vaginosis, candidiasis and PID...

Trichomonas Vaginitis

- Foul smelling d/c with vaginal itching, lower abdominal pain and dysuria
- 4-28d incubation period
- Exam shows foamy, yellow-green d/c with vaginal erythema and strawberry cervix
- Wet mount shows flagellated, motile, tear-drop-shaped protozoa with vaginal pH >5.5
- Tx with Flagyl
- Ass'd with PROM, preterm delivery and postpartum endometritis

“Strawberry Cervix”



Wet prep showing trichomonads

Vulvovaginal Candidiasis

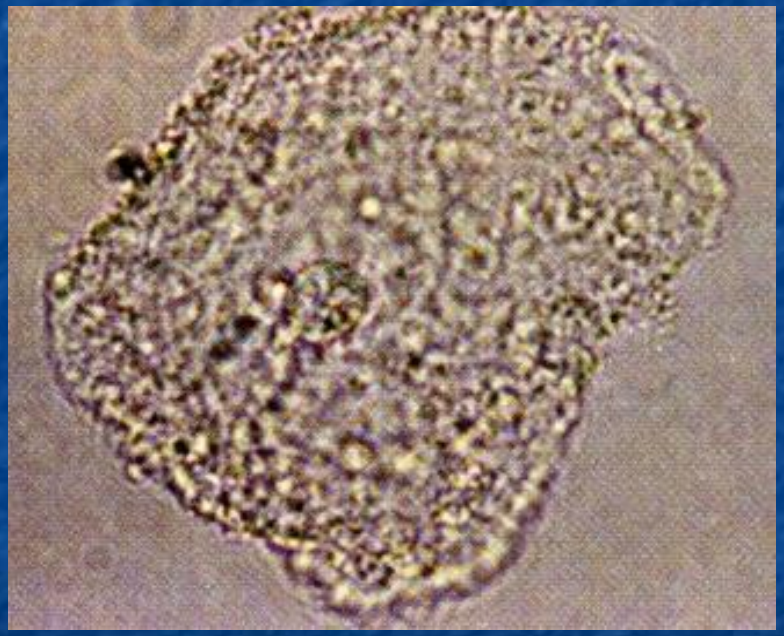
- Overgrowth of normal vaginal flora
- Pt with vaginal itching and thin, watery to thick, white d/c
- Exam reveals thick, cottage cheese d/c, vulvovaginal erythema, possible satellite lesions
- Vaginal pH <4.5
- tx with intravaginal azoles or po fluconazole

Fungus on wet prep without stain

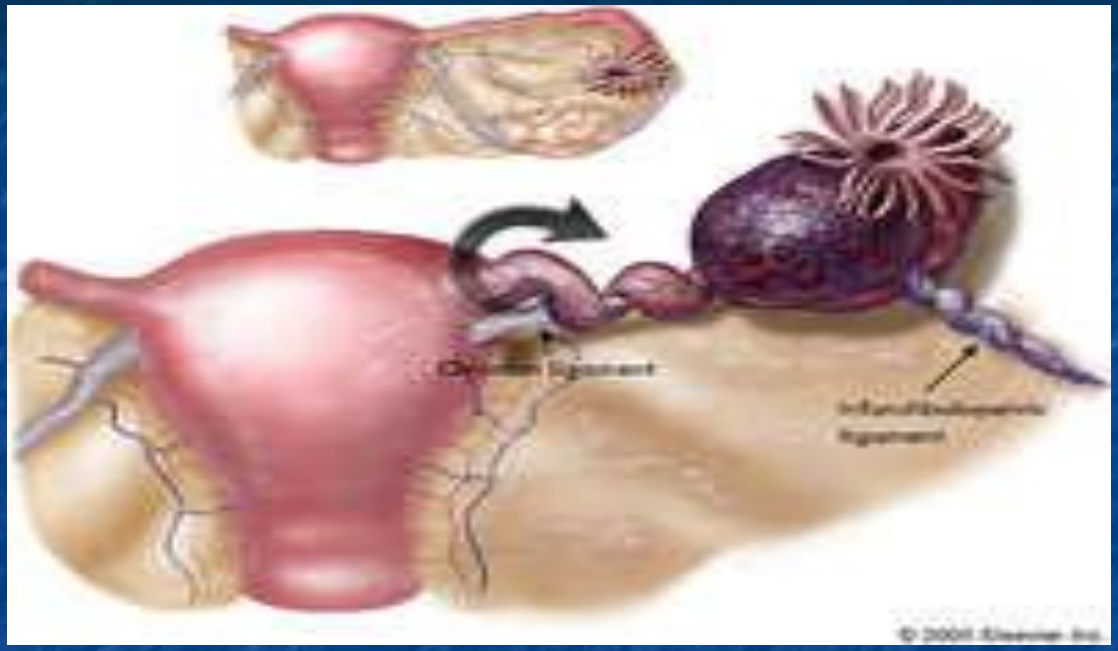
Bacterial Vaginosis

- The most common cause
- Believed to be polymicrobial
- Pt. complains of itching and fishy discharge
- Dx: must have ¾: homogenous d/c coating walls of vagina (doesn't pool), + whiff test, pH>4.5, clue cells on wet mount
- Tx with metronidazole or TV clinda
- Importance: increased PROM, preterm labor, preterm birth and post-cesarean endometritis

Clue cell on wet prep



Adnexal Torsion



- An ovary twists on its vascular pedicle causing compromised blood supply and necrosis.
- Usually secondary to an enlarged or overstimulated ovary
- May occur at any age and at any point in the menstrual cycles
- Hx of sudden onset, usually unilateral adnexal pain

Evaluation and Management:

- CMT may be present, may be bilateral though typically unilateral
- May palpate an adnexal mass
- Afebrile or tachycardic out of proportion to fever
- Routine labs are unrevealing.
- Ultrasound
- Tx is surgical
- Consequences include shock, peritonitis, tubal scarring

Abnormal Vaginal Bleeding (Non-pregnancy related)

There are multiple etiologies:

a. Endocrine alterations (menopause)
b. Drugs (ABX, anticonvulsants, anticoagulants)
c. Infections (Vulvovaginitis, Endometritis)
d. Neoplasms (Cervical, Polyps)
e. Post-operative
f. Trauma (Foreign bodies and straddle injuries)
g. IUDs (
h. Medical problems (Coagulopathies, Thrombocytopenia)
i. DUB (a diagnosis of exclusion)

Our responsibilities are the same...

- Assuring hemodynamic stability
- Stabilizing the life-threatening bleeds
- Identifying correctable causes

References:

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