

## Chapter 1 : Signs and Symptoms for Gynecologic Problems

*Gynaecological emergencies form a large proportion of the workload of a gynaecologist. Diagnosis and treatment of gynaecological emergencies have progressed markedly in the light of evidence-based practice and accurate diagnosis.*

Fitz-Hugh-Curtis syndrome is one of the serious sequelae of PID and presents with right upper quadrant pain secondary to liver capsule inflammation and perihepatitis. Ultrasound evaluation is generally not indicated unless there is suspicion of a possible tuboovarian abscess or an associated pregnancy. Emergency Department Management The diagnosis of PID is based on clinical evaluation as early treatment is necessary in order to minimize the possibility of serious complications. They should be educated about the importance of preventing STD spread and reinfection by having their male partners evaluated and treated appropriately. Lower abdominal pain, cervical motion tenderness, adnexal tenderness and a palpable adnexal mass are present. Ultrasound is the imaging tool of choice in confirming the diagnosis of TOA. Gynecologic consultation should be obtained. In most cases IV antibiotic therapy is the sole necessary treatment.

**Pediculosis Pubis** Pediculosis pubis is a cutaneous infestation with the louse, *Phthirus pubis*. Found in the area of pubic hair after contact with an infected individual, it is frequently transmitted through sexual contact. The adult form is approximately mm in length and the nits, small 0. Patients present with the complaint of severe itching in the pubic area and the diagnosis is confirmed by direct visualization of either the adult or nit form. The most effective treatment is Permethrin cream applied to the involved area. Lindane shampoo can be used as an alternative treatment but is contraindicated in pregnancy or lactation. All clothing and bed linens should be cleaned to eliminate sources of reinfection. All recent sexual contacts should be informed and subsequently treated.

**Pubic Scabies** This represents a highly contagious infestation by the mite *Sarcoptes scabiei*. The female mite which is approximately 0. Transmission usually occurs from intimate contact with an infected individual or with infested clothing. The clinical presentation is that of severe pruritis in the pubic area. Physical examination may show the presence of burrows which are noted as small less than 1 cm raised threadlike structures. Further confirmation of the diagnosis can be made by microscopic evaluation of skin scrapings to identify mites, eggs or fecal material. Machine washing of all clothing and bed linens in hot water reduces the incidence of reinfection. Antihistamines may be given for control of pruritis and the patient should be warned that this pruritis may persist for several weeks after treatment because of residual skin inflammatory response. Topical application of corticosteroids can help alleviate residual pruritis. These abscesses occur most frequently in women of reproductive age and present with a painful lump on the labia. The abscess is palpable as a tender fluctuant mass over the vulva on the involved side and are usually unilateral. Incision and drainage of the abscess using local anesthetic is the treatment of choice. The appearance of purulent drainage indicates successful penetration of the abscess wall. The abscess should be irrigated with normal saline and a Word catheter should be inserted to allow further drainage. The patient should be discharged on antibiotic therapy and be given gynecologic follow-up in two days for packing removal and further evaluation. Most patients can be treated as outpatients.

*Gynaecological disorders are a common cause of morbidity among women of reproductive age worldwide. In developing countries, gynaecological emergencies present enormous challenges given the weak health infrastructure in these settings.*

The Authors examined gynecologic emergencies INTRODUCTION In evaluation of gynecologic emergencies in women, particularly women of reproductive age, a delay in or improper management of the patient may compromise care and jeopardize future reproductive capabilities. Although there are several gynecologic urgencies that warrant expeditious management, there are only three life-threatening gynecologic emergencies: If these are kept constantly kept in mind, diagnostic failures should not occur and proper management of the similar-presenting but less concerning gynecologic urgencies will be enhanced. The objective of this chapter is to provide a suggested approach to the evaluation and management of the more common and important urgent and emergency gynecologic problems occurring in women of reproductive age. The chapter will focus on early pregnancy-related problems, ectopic pregnancy, adnexal accidents, abnormal genital bleeding conditions, and pelvic inflammatory disease PID. The possibility of an ectopic pregnancy must be considered in every patient who presents with a clinical scenario that includes lower abdominal or pelvic pain or abnormal uterine bleeding. A spontaneous abortion, infected abortion, hemorrhagic corpus luteum of pregnancy, and uterine incarceration are additional early pregnancy complications that frequently present to the emergency department ED. This incidence is increased with increasing maternal age, parity, and paternal age. The causes of spontaneous abortion are divided into two categories, fetal and maternal. Maternal factors include uterine abnormalities, incompetent cervix, intrauterine adhesions, progesterin deficiency, and serious medical problems such as diabetes and hyperthyroidism. Last menstrual period LMP. Not only the LMP, but also the timing of two or more immediate past periods should be ascertained to determine the intervals between "normal" menses. Any regularly menstruating woman whose LMP is greater than 4 weeks prior to the current date is very likely to be pregnant. If the LMP is determined to be normal and the patient is less than 4 weeks past the menses, the possibility of a pregnancy complication is highly unlikely, as spontaneous abortion and ectopic pregnancies do not present clinically before the first missed menses. If the stated LMP was lighter and shorter than normal, pregnancy must also be considered, since implantation can be associated with normal menstrual flow. Most spontaneous abortions also occur prior to 8 or 9 weeks of gestation; however, abortion can occur up to the 20th week of gestation. The aborting patient initially experiences minimal intermittent or continuous spotting that progresses to very heavy bleeding with the passage of clots and gestational tissue. Volume is best assessed by determining the number of pads used per day. A soaked pad suggest 20 to 30 mL blood loss. The pain associated with the abortive process usually occurs after bleeding has commenced and is very characteristically midline and cramping in nature, as opposed to the acute, severe, and unilaterally localized pain of an ectopic pregnancy or ruptured ovarian cyst. The abdominal examination of the aborting patient is usually unremarkable, with the possible finding of midline suprapubic tenderness to deep palpation. On pelvic examination, a patient with a threatened abortion will be found to have a closed cervical os and minimal bleeding. In a women with an actively progressing abortion, however, the bleeding will be profuse and accompanied by the passage of blood clots and products of conception through an obviously dilated cervical opening. The uterus will usually be enlarged to a size compatible with gestational dates unless significant tissue sloughage has occurred. In the case of a complete abortion, the uterus may be found to be small and firm shortly after all tissue has been passed. The adnexal examination is unlikely to be abnormal, although slight tenderness and palpation of a fullness on the side of the corpus luteum of pregnancy is common. It should be noted that a complete abortion is unlikely to occur beyond week 7 of gestation. Ultrasound has been used with relative reliability to determine if the uterus is empty if in doubt. In a full-blown abortive situation, the proper diagnosis is easy to determine. However, in earlier stages of the abortion process, a definitive diagnosis can be difficult and is easily confused with an ectopic pregnancy. An ultrasound examination can help to rule out an ectopic pregnancy if an intrauterine

gestational sac is seen and may even be predictive of a possible abortion if absent heart tones or irregular margins of the sac are seen. However, the rare case of a twin intrauterine and ectopic pregnancy should also be considered. When the diagnosis of an intrauterine pregnancy is uncertain, intrauterine instrumentation must be avoided until an accurate diagnosis can be made. Most patients with early pregnancy bleeding problems have normal pregnancy outcomes. Treatment Threatened abortion is defined as any uterine bleeding from a gestation of less than 20 weeks. If the diagnosis of a threatened abortion is made, the patient may be sent home for continued expectant management and close follow-up by her obstetrician. Discharge instructions should include bed rest, no intercourse, and no tampon use. The patient should be instructed to return to the ED if bleeding or cramping intensify, if orthostatic symptoms develop, or if there is fever or chills. Discharge instructions should include instructions for the patient to return if excessive bleeding, foul smelling menstrual blood, discharge, or fever ensues. Incomplete or inevitable abortion usually requires operative intervention with suction curettage. The time frame for performance of the procedure is dependent on the amount and rate of uterine bleeding. Missed abortion defined as fetal death before the 20th week of gestation or blighted ovum is not an operative emergency and can be scheduled accordingly. Continued bleeding, cramping pain, fever, nausea, and generalized malaise usually accompany a postabortive endometritis. On examination, a purulent, hemorrhagic cervical discharge is seen associated with a boggy, tender, and enlarged uterus. Significant adnexal tenderness may also be elicited if the myometrium, parametrium, and fallopian tubes are involved in the process. In severe cases where uterine perforation has occurred, an infected tender mass compatible with an abscess may be palpated in the adnexae or in the cul-de-sac. Patients with postabortive endometritis require hospitalization, intensive parenteral antibiotic therapy, and repeat dilatation and curettage in an effort to prevent abscess formation and development of septic pelvic thrombophlebitis. It can result from a fertilized ovum implanted in the abdomen, fallopian tube, cervix, ovary or peritoneal surface. Although changing etiologic factors are partly responsible, previous inconsistencies in reporting, improved diagnostic tools and an increase in acquired risks for the disease are some of the factors thought to contribute to the increase. Factors most commonly associated with ectopic pregnancy are assisted reproduction, in vitro fertilization, tubal surgery or tubal occlusion, and DES exposure. Diagnosis With recent technological advances the diagnosis of ectopic pregnancy can be made more accurately and earlier in gestation. As in the past, death is most often due to delay in diagnosis leading to rupture of the tube and hemorrhage. The clinical presentation of ectopic pregnancy is variable. The physician cannot rely on history and clinical findings as the only criteria, as they are often nondiscriminatory, particularly prior to the time bleeding and distention of the tube have occurred. The most common symptom associated with ectopic pregnancy is abdominal pain, followed by amenorrhea and vaginal bleeding. Women rarely present with dizziness and syncope. Clinical signs include abdominal and adnexal tenderness, adnexal mass, and varying uterine size. The usual presentation is a uterus which is softened but not as enlarged as expected for gestational age. These symptom characteristics are indeed altered by the presence of a combined gestation. However this number is thought to be increasing secondary to the increased numbers of assisted reproduction. In fact, recent estimates place the incidence at 1 to 8: Classical presentation of combined gestation is abdominal pain, adnexal mass, peritoneal irritation, and enlarged uterus. Other clinical scenarios in which one might think of combined gestation are a fundus compatible with dates in a person believed to have an ectopic; absence of bleeding following removal of an ectopic; and hemoperitoneum following a pregnancy termination. Differential diagnosis of a single ectopic gestation includes acute salpingitis, torsion, gastroenteritis, threatened or incomplete abortion or endometriosis. PID is the most common condition confused with ectopic pregnancy. Human Chorionic Gonadotropin hCG All currently used qualitative pregnancy tests are dependent on the ability to detect in serum or urine human chorionic gonadotropin, a glycoprotein hormone produced by trophoblast. A patient in whom hCG levels fall, plateau, or fail to reach a predicted slope has an abnormal pregnancy. The absolute value of a single hCG is not useful to determine the location of a pregnancy. However, ectopic gestations have a lower increase in hCG titer. The current monoclonal antibody technology allows detection of hCG within 2 to 3 days postimplantation. Serial hCG levels help to assess the viability of pregnancy and can be used to signal the optimal time for ultrasonography. In addition, after medical treatment with either an abortifacient or systemic

methotrexate falling hCG levels help determine the effectiveness of treatment. Progesterone Testing of single serum progesterone has recently emerged as a controversial tool for the evaluation of potential ectopic pregnancy. This tool has been used as an absolute value to determine the diagnosis of normal or ectopic pregnancy or as a mechanism for assigning risk by using a discriminatory cutoff to distinguish a normal from an abnormal pregnancy. Use of this diagnostic tool is attractive as only one measure need be obtained. Their data indicate that serum progesterone is a better predictor than hCG doubling time. Of note, however, is that the lowest progesterone level associated with a normal pregnancy is 5. This finding demonstrates the difficulty one has in using only serum progesterone to determine rather than predict the diagnosis. Normal intrauterine gestation is reported to exist in the presence of a low progesterone. Thus, this test should only be used to assign risk of an abnormal pregnancy and not as sole diagnostic criteria. Ultrasound Further localization of the pregnancy can then be attempted with a real-time ultrasound examination of the pelvis, the findings on which will be greatly dependent on the gestational age and the type of sonographic approach used. In general, real-time sonography using an abdominal transducer can find an interuterine gestational sac by the fifth week, a sac with an embryonic or fetal pole by the sixth week, and an embryonic mass with cardiac motion by the seventh week. The recent use of high resolution transvaginal US has improved the accuracy of diagnosis and decreased the gestational age at which an ectopic pregnancy can be diagnosed. The specificity was Depending on the skill of the examiner, resolution of the probe and size and location of the ectopic pregnancy, pregnancies can be detected at as little as 31 to 32 days post-LMP. Color doppler allows even better visualization of an ectopic gestation. It is important to remember that ultrasound is still considered diagnostic of an ectopic only when the sac is visible outside the uterus. Culdocentesis Whenever ectopic pregnancy is suspected culdocentesis may be used to determine whether intraperitoneal hemorrhage is present. If a significant hemorrhage has occurred, cervical motion tenderness may be present accompanied by cul-de-sac fullness or bulging. With or without such a finding, however, culdocentesis should be considered in all patients with a suspected ectopic pregnancy. Culdocentesis is negative if clear fluid is aspirated and positive if nonclotting blood is aspirated. Failure to aspirate blood on culdocentesis is nondiagnostic and may represent technical difficulties. Dilation and Curettage and Laparoscopy After identifying an abnormal pregnancy with either progesterone, serial hCG or ultrasound, curettage can be used to identify villi, rendering the diagnosis of ectopic gestation remote. Treatment Management of the unstable patient with ectopic pregnancy is aimed toward hemodynamic support. Oxygen should be administered and volume resuscitation started immediately. The patient should be given type-specific blood as indicated. Immediate gynecologic consult for surgical management is the obvious next step. With the increased use of tubal conservation procedures the risk of repetitive ectopic pregnancy is increased. Management of the stable patient varies depending on the degree of suspicion and the possible gestational age.

**Chapter 3 : Common Oncologic Emergencies**

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**Abstract Background** The role of various gynaecological imaging modalities is vital in aiding clinicians to diagnose acute gynaecological disease, and can help to direct medical and surgical treatment where appropriate. **Methods** Ultrasound and Doppler are readily available in the emergency department, and demonstrate features of haemorrhagic follicular cysts, ovarian cyst rupture, endometriotic cysts and pyosalpinx. Adnexal torsion may also be identified using ultrasound and Doppler, although the diagnosis cannot be safely excluded based on imaging alone. Computed tomography CT is not routinely employed in diagnosing acute gynaecological complications. However due to similar symptoms and signs with gastrointestinal and urinary tract pathologies, it is frequently used as the initial imaging modality and recognition of features of gynaecological complications on CT is important. **Results** Although MRI is not frequently used in the emergency setting, it is an important modality in characterising features that are unclear on ultrasound and CT. **Conclusion** MRI is particularly helpful in identifying the site of origin of large pelvic masses, such as haemorrhagic uterine fibroid degeneration and fibroid prolapse or torsion. In this article, we review the imaging appearances of gynaecological emergencies in non-pregnant patients. **Gynecology, Emergencies, Ultrasonography, Doppler, Tomography scanners, X-Ray computed, Magnetic resonance imaging, Ovarian cysts, Endometriosis, Dermoid cyst, Torsion abnormality, Leiomyoma, Pelvic inflammatory disease** **Introduction** Acute abdominal pain related to the gynaecological tract is a common presentation in the emergency department. One of the challenges facing clinicians is the wide range of differential diagnoses that must be considered when assessing abdominal pain. Often it can be difficult to distinguish gynaecological from gastrointestinal emergencies. In conjunction with clinical findings, various imaging modalities play an important role in diagnosing the cause of pain. In patients presenting with pain that is thought to originate in the gynaecological tract, ultrasound is usually employed as the first imaging modality as it is highly sensitive, fast and easy to access. CT is seldom used as an initial diagnostic tool in suspected gynaecological emergencies due to the risks associated with irradiating the pelvis. However, it may be difficult to localise the site of origin of the symptoms to the gynaecological tract due to the significant overlap in symptoms and signs with gastrointestinal pathologies, and CT may be selected as the first imaging modality. MRI is not usually used in the acute setting but may be important in characterisation of abnormalities that remain indeterminate following ultrasound or CT. **Cyst Emergencies** **Functional or simple cysts** Ovarian follicles are frequently identified on ultrasound and CT. If ovulation does not occur, a follicular cyst develops and appears as an anechoic cyst with a thin wall and posterior acoustic enhancement seen as an area of increased echogenicity posterior to the cyst. Follicular cysts usually reabsorb within a 4- to 8-week period [ 1 ]. The corpus luteum forms after ovulation as granulosa cells become luteinized and blood accumulates in the central cavity. Hence, corpus luteal cysts have a thicker, more echogenic wall with increased vascularity seen as peripheral blood flow on Doppler [ 2 ]. **Haemorrhagic ovarian cyst** A haemorrhagic ovarian cyst is suspected if a patient presents with symptoms of acute lower abdominal pain, tenderness and in some cases ascites [ 2 – 4 ]. Blood tests often show normocytic anaemia with only mild elevation of inflammatory markers such as CRP and leucocytes when compared to conditions such as appendicitis. A transvaginal ultrasound is often the first imaging modality in patients who are suspected of having an ovarian cyst haemorrhage. When there is an intracystic haemorrhage the characteristics of the bleed evolve with its age. In the acute stage, the haemorrhage is isoechoic in relation to the ovarian stroma and this can often be similar in appearance to an enlarged ovary. Sometimes a fluid debris level may also be seen and often, as the clot matures, it may attach to the wall of the cyst, giving it a thick-walled appearance [ 2 , 5 , 7 ]. The use of Doppler is often used to help distinguish between malignant and benign ovarian cysts. Doppler US may demonstrate the vascular wall and the avascular internal lace-like appearances of a haemorrhagic corpus luteum cyst [ 8 ]. When performing

ultrasound, it is important to exclude the presence of intraperitoneal fluid in order to exclude haemorrhagic cyst rupture. However, ultrasound has its limitations in trying to identify whether a haematoma is originating from the fallopian tube or from the ovary. In addition, the nonspecific characteristics of the presenting pain can often make CT a more attractive first investigation in the acute setting as it can exclude other intra-abdominal causes.

**Chapter 4 : Gynaecological Emergencies in the Tropics: Recent Advances in Management**

*PID is common and can be disabling as well as damaging to the reproduction of the female and the spouse.*

Other diagnostic procedures include imaging techniques such as ultrasound, computerised tomography and magnetic resonance imaging, culdocentesis and endometrial biopsy. Treatment Since there are no reliable clinical diagnostic criteria, empirical treatment is recommended. This includes appropriate antibiotic therapy, analgesics and intravenous fluids. If there are signs of generalised peritonitis suggestive of burst abscess, laparotomy with drainage of the abscess is necessary [ 4 ]. Laparotomy should also be performed if the woman remains unwell and abscess is not becoming smaller after 48 hours of supportive therapy. Choice of antibiotics should cover N. However, local sensitivity patterns should guide the choice of antibiotics. The goals of treatment are to relieve the acute symptoms and prevent long term sequelae of PID. It is conventional to start treatment with parenteral therapy followed by oral therapy after clinical improvement and to continue treatment for 14 days though there is no evidence on the optimal duration of treatment or route of administration. Contact tracing is essential and sexual contacts should be treated. Sexual abstinence is also advised until cure is achieved. It is conventional to remove any intrauterine contraceptive device if present when diagnosis of PID is made. Randomised control trials and observational studies have shown that removing an IUCD does not alter response to treatment [ 42 ]. However, IUD removal is recommended in severe illness that warrants hospitalization. Recent studies indicate that oral out-patient treatment is as effective as in-patient parenteral treatment for mild - moderate cases of PID. However the following criteria have been established by CDC for hospitalization based on observational data and consensus opinion [ 39 , 43 ]: Prompt and adequate treatment will reduce long term complications of PID such as ectopic pregnancy, chronic pelvic pain and tubal factor infertility. PID is preventable; and cost effective strategies for prevention of PID in developing countries appear feasible. Primary prevention includes public enlightenment campaigns about sexually transmitted infections, promotion of safer sex practices including use of barrier methods, delaying the onset of sexual activity and antibiotic prophylaxis for women undergoing vaginal operations. Early diagnosis and adequate treatment of lower genital infections and upper genital tract infections to prevent long-term complications are the secondary and tertiary preventive approaches respectively.

**Adnexal Masses**  
Adnexal masses complicated ovarian cysts and tuboovarian abscess are common gynaecological emergencies that typically present with lower abdominal pain. Most ovarian cysts that undergo complications are functional cysts particularly in younger women. However, ovarian cysts may be malignant especially in older women. Complications of ovarian cysts include haemorrhage, rupture, torsion and infection. Acute or sub acute symptoms may result from these complications. All could present with abdominal pain or referred pain along the cutaneous distribution of obturator nerve, i. Ultrasound is central to the diagnosis and management of tubo-ovarian abscess. Ultrasound is unable to clearly define the borders of the ovaries and fallopian tubes; these structures are thus described as the tubo-ovarian complex. Analgesia, intravenous fluids and antibiotics are required. Prompt surgical intervention should be employed in patients with ruptured tubo-ovarian abscess with generalized peritonitis and septic shock [ 4 ]. Ultrasoundguided drainage, colpotomy, percutaneous drainage, ultrasound-guided transvaginal aspiration have been described, but the results are inconsistent [ 2 ].

**Torsion of Ovarian Cyst**  
This is unusual with adnexal masses less than 5cm in diameter [ 44 ]. Most cases occur in women of reproductive age. Ovarian torsion may also occur in association with ovarian hyper-stimulation syndrome OHSS where saving and conserving the ovaries is crucial. Ovarian torsion occurs twice as common on the right probably due to the presence of sigmoid colon on the left [ 45 ]. Patients with ovarian torsion classically present with acute or sub-acute abdominal pain, nausea and vomiting and mild shock. There may be lower abdominal tenderness, rigidity and tenderness. Pelvic examination will reveal tender adnexal mass. There is leucocytosis and low grade fever. Ovarian torsion may also present with episodes of recurrent pain over a long period as the pedicle twists and untwists. Finally the pain becomes continuous as the ovarian blood supply is cut off and the ovary becomes gangrenous. Misdiagnosis is common and by the time patient comes to surgery, ovarian infarction has already occurred. Rupture of Ovarian Cyst

Ovarian cyst may rupture spontaneously or traumatically and signs and symptoms will depend on the amount and character of the cyst content. Rupture of small cyst may be silent but large cyst rupture may cause peritonitis and shock. The contents of endometriotic and dermoid cysts are extremely irritant and hence cause severe symptoms such as abdominal pain, collapse and signs of acute abdomen. However content of serous cyst are significantly less irritant. Rupture of mucinous cystadenoma leads to dissemination of cells causing development of pseudomyxoma peritonei. Haemorrhage Small haemorrhages are common in normally functioning ovaries. Slight bleeding also occurs regularly in the vascularization phase of corpus luteum but if excessive, may lead to formation of corpus luteum cyst. Haemorrhage can occur from the torn edge of a ruptured cyst or into the cavity of a cyst. Intraperitoneal bleeding involving ruptured corpus luteum cyst usually mimics ectopic pregnancy. The rupture often occurs on day and two-third of cases occurs on the right [ 45 ]. Symptoms and signs include severe lower abdominal pain and tenderness. Patient may be anaemic and negative pregnancy test will differentiate it from ectopic. Infection of Ovarian Cyst Infected cysts causing abscess formation are usually a feature of acute pelvic inflammatory disease [ 4 ]. One percent of ovarian dermoid cyst becomes infected. Endometriotic cyst is particularly prone to secondary suppurative inflammation. Most offending organism implicated in infected ovarian mucinous cystadenoma, dermoid cyst and endometriotic cyst is salmonella typhi [ 46 , 47 ]. In addition to signs of acute abdomen, constitutional symptoms such as fever and tachycardia may be present. Rupture of the infected cyst leads to pelvic or generalized peritonitis. Accurate diagnosis may be difficult but a triad of ovarian cyst, signs of infection without any other source of infection and immunosuppression should heighten the suspicion of infected ovarian cyst [ 4 ].

**Diagnosis of Complications of Ovarian Cysts** Diagnosis is based on clinical symptoms and signs as described above. Differential diagnoses of adnexal accident include ectopic pregnancy, appendicitis, appendix abscess, acute PID, diverticulitis, urinary tract infection and ureteric colic. Detailed history of presenting complaint, full gynaecological history, thorough physical examination and in some instances, ancillary investigations will assist in making accurate diagnosis. The investigations required will depend on the circumstances of the presentation. Relevant investigations include haemoglobin level, white blood cell count and coagulation profile including assessment of platelets. Pregnancy test is important to exclude ectopic pregnancy. Urine microscopy and culture and blood culture may also be required. Pelvic ultrasound is very useful in the evaluation of ovarian cyst. Ovarian dermoids and endometriomas have characteristic sonographic features [ 48 ]. Dermoids may be predominantly cystic or solid on ultrasound with posterior acoustic shadowing. Fine short echogenic strands may be seen within the cystic component representing hair. In ovarian cyst torsion, fluid “fluid levels may be seen representing haemorrhage into the cyst but could also be completely anechoic in other cases after absorption of the blood [ 45 ].

**Treatment** Except in mild or early cases, most patients with complicated ovarian cysts will require surgical intervention. However conservative management is indicated in patients with Von Willebrands disease or known haemophiliac presenting with haemorrhagic ovarian cyst response is usually rapid following therapy with factor VIII and patients with ovarian hyperstimulation syndrome OHSS [ 45 , 49 ]. For most cases of ovarian cyst accidents with acute or subacute symptoms, laparoscopy or laparotomy is usually required. Surgical procedures employed to manage ovarian cysts include aspiration and fenestration, cystectomy, oophorectomy or salpingo-oophorectomy. The disadvantages of aspiration and fenestration removal of a window of the cyst for histological analysis include recurrence, spillage of cyst contents and failure to diagnose malignancy. In a woman of less than 35 years of age, ovarian cysts are rather unlikely to be malignant. Thus, ovarian cystectomy or unilateral oophorectomy are safe treatments for unilateral ovarian cyst in this age group with preservation of reproductive potential.

**Menstrual Disorders** Disturbances of menstruation are a major social as well as medical problem for women, having an impact on the lives of their families as well as the women themselves [ 50 ]. Menstrual disorders are not common gynaecological emergencies. Heavy menstruation is the most common form of presentation. Although menorrhagia may result from underlying pathology such as fibroids, malignancy, infection and other bleeding diathesis, in the vast majority of cases there will be no organic disease and bleeding is termed dysfunctional [ 50 ]. This can be measured accurately using alkaline-haematin method. Clinical history will elucidate the severity of the bleeding and may reveal underlying disease. General examination should focus on

signs of anaemia and systemic examination may detect abnormalities in the pelvic or abdomen. Treatment An adolescent or a younger woman suffering from acute menorrhagia can be treated with intravenous conjugated oestrogen 2. Alternatively, monophasic oral contraceptives containing mcg of estradiol can be used for stabilization at a dose of one tablet thrice daily for 3 days then twice daily for 2 days and subsequently once daily until the pack is finished. The pill can be continued in the standard fashion for two months. Synthetic progestogens such as norethisterone and medroxy-progesterone acetate may also be useful [ 50 ]. For older women who complain of menorrhagia, detailed investigation is necessary if there are associated irregular bleeding pattern. Bleeding from Gynaecological Malignancies In some situations, advanced stages of cervical cancer may cause life threatening haemorrhage due to vascular erosion. Sub-urethral nodules secondary to metastatic deposit from choriocarcinoma may also cause severe acute haemorrhage. In these situations, bed rest, vaginal packing and application of Monsel solution to the lesion can be used to arrest the haemorrhage. Other treatment modalities include the use of haemostatic dose of external beam radiotherapy. Adequate blood transfusion should be given as appropriate. The patient can then be prepared for full treatment. Where facilities exist, embolism of internal iliac or uterine arteries may also be used [ 51 , 52 ].

### Chapter 5 : Gynaecological emergencies | StratOG

*Aimed at the newly qualified doctor or final stage medical student, this book covers emergencies likely to be encountered in British gynaecological practice, as well as some conditions to be found.*

### Chapter 6 : PPT “ GYNECOLOGIC EMERGENCIES PowerPoint presentation | free to view - id: 1cbYTK

*Overview of Gynaecological Emergencies, Contemporary Gynecologic Practice Atef Darwish, IntechOpen, DOI: / Available from: Dagogo Semenitari Abam (February 4th ).*

### Chapter 7 : GYNECOLOGIC EMERGENCIES

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### Chapter 8 : Radiological appearances of gynaecological emergencies

*Common Presentations Pelvic Pain Infections Vaginal Discharge Vaginal Bleeding Contraceptive Problems 7. Gynaecological Emergencies Diagnostic challenges Overlapping and similar symptoms Must rule out Pregnancy (esp. ectopic) Non-gynaecological causes 8.*

### Chapter 9 : Gynecologic Emergencies - Clinical Presentation, Treatment

*Presentation to the accident and emergency department with an obstetric or gynaecological complaint is common--the average incidence being around 1 in but is still associated with considerable problems.*