# Sexual Health Medicine Advanced Training
## Record of Cases

| | Date | Age of Patient | Diagnosis or Condition | Management/Reflections/Outcomes |
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| 1. | [redacted] | 46 | Review after Levonorgestrel IUD (LNG-IUD) insertion | 42 yo female, RMP (18 years). Uses Levonorgestrel IUD (LNG-IUD) for contraception. Presented 3 weeks ago for replacement of old IUD. Placement was uncomplicated without immediate symtpoms or signs of perforation. Currently has no side effects. No change in bleeding pattern, no history of expulsion and no symptoms of infection.<br>No anomaly detected on examination. IUD string visible and appropriate length.<br><br>Reflection: Women are asked to return for review 3-4 weeks after IUD placement. The follow up visit is important to assess the bleeding pattern and to examine for signs of perforation, expulsion and infection. We also again discuss the chance of pregnancy, being 1 in 1,000. In the rare event of a pregnancy with a Mirena® in the uterus there is a small risk of a miscarriage or ectopic pregnancy. Women are reminded to have their IUD replaced with a new device every 5 years to work effectively. |
| 2. | [redacted] | 23 | Complication post IUD insertion | 23 yo female, RMP (1 year). Nulliparous. Initial IUD inserted. Found in cervical canal at first review visit. Was removed and replaced. Returned for review of second IUD. Reports very short strins. Some discharge, but no pain or bleeding. No infection. No anomaly on examination. Strings found to be at approprate length with no sharpness. No STIs. Reassured and further education provided.<br><br>Reflection:<br>Sometimes the Mirena® device may be partially or completely pushed out by the uterus. It occurs in about 5 per 100 insertions. It is important to check for the threads after each period in the first few months after insertion. Nulliparity—insertion may be more difficult and risk of expulsion is higher. |
| 3. | [redacted] | 21 | IUD removal and contraceptive aducation and discussion regarding PCOS and subfertility | 21 yo, RMP (2 years). Nulliparous. Requesting removal due to ovarian cysts. Initially presented with intense left sided pain, which started a few months after insertion. Past medical history 5 - 7 year of recurrent ovarian cysts. USS done recently showed no abnormailiets. Alternative contraceptives discussed. Thinking of starting with a family in the near future and wants to discontinue all contraceptives.<br><br>Reflection:<br>Cyst of ovary<br><br>1) Incidence: Liletta(TM), 4.3%; Skyla(TM), 13.2%; Kyleena(TM), 22.2%<br>2) General Information |

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| | | | | a) Led to treatment discontinuation in 0.3% to 0.6% of patients<br>b) Mostly asymptomatic, although some may be associated with pelvic pain or dyspareunia<br>c) Cysts usually disappeared spontaneously over 2 to 3 months of observation in a majority of cases.<br>d) Defined in clinical studies as abnormal, non-functional cysts or having a diameter greater than 3 cm on ultrasound<br>e) Ovarian disorders, including cyst, mass or enlargement led to hospitalization in 0.4% of patients who received subdermal levonorgestrel (Study N=1393)<br>3) Prevention and Management<br>a) Evaluation is recommended for persistent ovarian cysts.<br>b) Surgical intervention may be necessary in some cases if the cyst twists or ruptures |
| 4. | [redacted] | 26 | Assessment for IUD placement | 26 yo, RMP (4 years). Nulliparous. Has current Mirena in situ (5 years). No problems with current IUD. Would like replaced. Pregnancy excluded. Pre-procedure analgesia discussed. Last pap smear 2 years ago (NAD), repeated today as per current screening guidelines. No abnormal vaginal or post-coital bleeding. Monogamous relationship and declining offer of STI screening. Patient fully informed and educational material provided. Assessment check list done. Script provided. Will return tomorrow for removal and replacement. Will bring support person to drive her home afterwards.<br><br>Reflection:<br>Some of the advantages of Mirena® as a method of contraception include:<br>• highly effective, approximately 99.9%.<br>• long acting (effective for 5 years)<br>• reversible and fertility returns within a month<br>• reduces amount of blood loss with periods<br>• reduces period and pelvic pain<br>• does not interfere with breastfeeding<br>• cost effective over 5 years |
| 5. | [redacted] | 28 | Assessment for Implanon insertion | 28 yo, no regular male partners. Has had a few Implanons in the past. This would be her 4th consecutive. Reports no side effects and happy with amenorrhoea. No medical conditions, medications or allergies. Pregnancy test negative. STI screening requested via self collected vaginal swabs. Patient education material provided. Script provided. Returning later today for removal of old and insertion of new Implanon.<br>Written informed consent. Removal and insertion without complication. Follow arranged.<br><br>Reflection:<br>Some of the advantages of Implanon NXT®?<br>· Highly effective (99.9%). |

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| | | | | · Long-acting (lasts three years)<br>· Reversible and rapid return to usual fertility (most women ovulate within the first month after removal of the implant)<br>· Inexpensive - cost effective<br>· A small percentage of women have no vaginal bleeding, incidence: 14% to 33%<br>· Less period pain for some women<br>· No pills - no injections |
| 6. | [redacted] | 31 | IUD insertion | 31 yo, G2P2, NVD2, RMP (10 years). No current contraception, but has 2 IUDs in the past. Currently day 3 of cycle (normal in timing and duration). Was fully councelled and educated last week during pre-insertion consultation. Pregnancy test negative. Pap smear done last week, normal. No medical conditions, regular medication or allergies. No history of uterine abnormalities. Written informed consent obtained. On examination retroflexed uterus with posterior cervix. Sterile procedure. Sounded at 7cm. Insertion without complication. Aftercare instructions provided and follow up arrangements made.<br><br>Reflexion:<br>Uterine perforation by intrauterine contraceptive device:<br>1) Incidence: Intrauterine route, less than 0.1%<br>2) General Information<br>a) The risk of perforation may be higher when insertion is performed during lactation or when the uterus is fixed retroverted or not completely involuted during the postpartum period.<br>b) Perforation may reduce efficacy of contraception and lead to pregnancy, and may be associated with severe pain and continued bleeding.<br>c) Delayed detection of perforation or removal of device may result in migration outside the uterus, adhesions, peritonitis, intestinal perforations or obstruction, or abscesses and erosion of adjacent viscera.<br>3) Prevention and Management<br>a) To reduce the risk of perforation postpartum, delay inserting intrauterine system at least 6 weeks after delivery or until involution is complete after a delivery or second-trimester abortion.<br>b) Consider waiting until 12 weeks postpartum if involution is significantly delayed.<br>c) Remove the intrauterine system as soon as possible if perforation is suspected; surgical removal may be necessary.<br><br>Uterine spasm:<br>1) Incidence: 2.4%<br>2) General Information<br>a) Led to treatment discontinuation in 0.7% up to 1.3% of patients |

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| 7. | [redacted] | 46 | Regulation of menses | 46 yo, RMP (16 years). Been using DMPA for 10 years. Discussed the risk of decreased bone mineral density with prolonged use and also discussed alternative contraceptive options. Patient is very happy with amonorrhoea secondary to DMPA. Difficulty with multiple different contraceptives in the past has made her completely opposed to alternatives. Patient aware of the risk and had a bone density scan done 1 month ago, which was normal. Vitamin D levels normal as well. Has no spotting or post coital bleeding. Normal pap smear within the past two years. No chronic medical conditions, no medications or allergies.<br>Reflection:<br>Decreased bone mineral density:<br>Significant loss of bone mineral density (BMD) has been reported with use of DMPA injection. Increased duration of DMPA use appears to result in greater bone loss, which may not be completely reversible. The effects of DMPA on bone growth, peak bone mass, and the potential risk for future osteoporotic fractures in adolescent and young adult women is not known. Because of the potential for substantial BMD loss, DMPA should not be used as a long-term (ie, greater than 2 years) method of contraception unless alternative contraceptive methods are not adequate. BMD evaluations should be performed with continuous, long-term use of DMPA. DMPA can increase the risk in patients with risk factors for osteoporosis (eg, metabolic bone disease, chronic alcohol and/or tobacco use, anorexia nervosa, strong family history, or chronic use of drugs that can reduce bone mass). All patients receiving medroxyPROGESTERone acetate should have adequate calcium and vitamin D intake<br>References:<br>Product Information: DEPO-PROVERA(R) CI IM injection suspension, medroxyprogesterone acetate IM injection suspension. Pharmacia & Upjohn Company (per FDA), New York, NY, 2011. |
| 8. | [redacted] | 25 | Menorrhagia and primary dysmenorrhoea | 25 yo, no RMP, is sexually active. Currently on Microgynon 30 for contraception. Ongoing symptoms of menorrhoea and primary dysmenorrhoea (fully investigated). STI screening and pregnancy test negative, pap smear normal, normal pelvic ultrasound scan. Management options discussed, including NSAID use to relieve symptoms of primary dysmenorrhoea - finds this helpful. Wishes to try Mirena IUD to manage menorrhagia. Fully informed consent. Proceeding with LNG-IUD insertion.<br><br>Reflection:<br>LNG-IUD reduces menstrual bleeding and is associated with an improved quality of life in women with heavy menstrual bleeding. It also reduces primary dysmenorrhoea, pain associated with endometriosis and adenomyosis. LNG-IUD may be associated with a reduced risk of ovarian and endometrial cancer.<br>She was advised to continue using the COCP for another 7 days for pregnancy prevention. She returned 4 weeks later and reported no side effects. |

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| 9. | [redacted] | 49 | Menopause | 49 yo, not sexually active. Presents with a 7 month history of hot flushes, night sweats, irritability, sleep disturbance, lessened concentration, vaginal dryness, fatigue, crawling sensations on skin and muscle/joint pain. Uterus intact. Periods still regular, but heavy. Recent normal pap smear and mammography. No personal history of chronic disease, regular medications or allergies. No family history of oestrogen dependant tumours. Comprehensively assessed for heart disease, osteoporosis risk and mood disorders. Non smoker. Discussed symptom management, including lifestyle modification, SSRI and hormone replacement therapy (HRT). Fully informed decision to start on HRT. Started on Sandrena (topical estradiol) & Mirena inserted.<br><br>Reflection:<br>Treatment options during the menopausal transition include:<br>Dosage: lowest effective dose monitored by self-reported symptom control<br>Options:<br>1. Low dose combined contraceptive<br>(if low CVD risk & <50 years)<br>2. Continuous oestrogen<br>+ cyclical progestogen 10-14 days each month<br>+ contraception (including barrier, sterilisation)<br>3. Continuous oestrogen<br>+ levonorgestrel IUD for progestogen and<br>contraception |
| 10. | [redacted] | 26 | Troublesome vaginal bleeding with Implanon | 26 yo, no regular sexual partner. Implanon in situ for 18 months. Requesting removal due to unacceptible irregular bleeding. Pap smear normal and STI screen negative. Has been on OCP in the past with no side effects and would like to restart. No known medical conditions, regular medications or allergies. Non smoker, normal BMI, no VTE risk. UKMEC 1. Implanon removed and started back on Microgynon ed 150/30.<br><br>Reflection:<br>Expected bleeding patterns with Implanon:<br>1/5 amenorrhoea, 3/5 infrequent, irregular bleeding, 1/5 frequent or<br>prolonged bleeding; approximately 1/2 with frequent or prolonged bleeding will<br>improve after three months.<br><br>Management of troublesome bleeding:<br>1. Exclude other causes<br>Pregnancy, sexually transmitted infections (STIs) including chlamydia, liver-enzyme inducing medications (implant only) and vaginal, cervical or uterine pathology<br>2. If no suspicion of another cause for bleeding<br>Reassure this is 'normal' and not harmful |

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| | | | | 3. Advise medication management<br>Ensure no contraindications and explain risks and side effects<br>4. Advise that the implant can be removed any time.<br><br>Management options:<br>First line options:<br>• A combined hormonal contraceptive taken continuously or cyclically for three months<br>• Five day course of NSAID such as mefenamic acid 500mg bd-tds<br>• Five day course of tranexamic acid 500mg bd, particularly if bleeding is heavy<br>Second line options<br>With low level, anecdotal or conflicting evidence:<br>• Tranexamic acid 500mg bd for five days for lighter bleeding<br>• Norethisterone 5mg tds for 21 days<br>• Levonogestrel, progestogen only pill, 30 mcg bd for 20 days<br>• Early removal and replacement of implant |
| 11. | [redacted] | 53 | Menopausal symptoms | 53 yo. Not currently sexually active. Discussed menopause management at length during previous consultation. Wishes to not use oral or topical HRT. Was started on Venlafaxine and vagifem (for vaginal dryness) with very good response. PMH: hypertension, well controlled on Sevikar. Cervical and breast screening up to date. No contra-indication for oestrogen therapy. Requesting repeat prescription for Venlafaxine and Vagifem.<br><br>Reflection:<br>For woman seeking alternatives to oral or topical HRT, general advise would include:<br>• Hot flushes – dress in layers, natural fibres, reduce weight, reduce alcohol, increase activity, reduce caffeine, healthy diet<br>• Dry vagina – local treatments: vaginal oestrogen cream, pessaries and tablets. Encourage patients to select vaginal lubricants and moisturisers most similar (in pH and osmolality) to natural vaginal secretions, as this may make them less likely to cause irritation.<br><br>Alternative for the management of vasomotor symptoms include:<br>• Escitalopram 10-20mgs daily • Venlafaxine 37.5-75mgs daily • Desvenlafaxine 50-100mgs daily • Paroxetine 7.5-10mgs daily • Gabapentin 300-900mgs daily • Clonidine 50-150mcg daily |
| 12. | [redacted] | 24 | Contraceptive advice | 24yo. No regular sexual partner.<br>Difficulty finding an appropriate contraceptive<br>Mainly using it for controlling dysmenorrhoea<br><br>Has had a history of headache associated with COCP use |

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| | | | | - been fully investigated by GP with bloods and MRI brain<br>- found benign cyst in brain<br>Contraceptives tried:<br>Yasmin from 15 to 20 years of age<br>Microgynon 20 - headaches (not migraine in nature)<br>Microgynon 30 - headaches and distured vision<br>Has used progesterone only in the past - has caused dry skin and eyes<br>Has been on Yaz for the past 3 months<br>- blurred vision again for the past month<br><br>Options discussed:<br>- depo injections every 3 months<br>- implanon<br>- mirena IUD (has had copper IUD which did not agree with her)<br>Will consider above options and return once she's read up on them all<br>Not keen to do anything until she's done her own research<br><br>Reflection:<br>This case was a good reminder that finding the right contraceptive for the individual can sometimes be very tricky. She has had bad experiences in the past and was difficult to educate with regards to other available options. As she is currently sexually active and uses condoms only on occation, she is at increased risk of unplanned pregnancy. It was difficult to explain the benefits of contraception to her. I have explained to her that we are very fortunate to have a large variety of possible contraceptive measures and attempted to reassure her that diffirent methods may have diffirent (and sometimes very positive) side effects. She agreed to return next week. |
| 13. | [redacted] | 20 | Lowered libido while on COC | 20 yo, RMP. Currently taking Levlen ED (levonorgestrel 150 mcg, ethinylestradiol 30 mcg)<br>Low libido - longstanding, irrespective of partner or sexual practice<br>Feels it may be related to the pill as better when on placebo<br>Would like to change<br>No contra-indictaions<br>Discussed options. Would like to trial Yasmin (drospirenone 3 mg, ethinylestradiol 30 mcg).<br><br>Reflection:<br>The experience of sexual dysfunction during use of a COC is a predictor of discontinuation. A placebo randomised controlled trail using a COC (150mcg LNG and 30 mcg EE) in the intervention arm, showed no overall effect on sexual function but did show a significant negative impact on desire, arousal and pleasure.<br>There is insufficient evidence to determine whether use of CHC affect mood. While there is no evidence about whether a change of pill formulation can have an effect on these symptoms, |

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| | | | | induvidual women may respond differently to different COC types and it may be useful to consider a trail of a different pill type. |
| 14. | [redacted] | 21 | Expulsion of IUCD | 21 yo, RMP for past 8 months. G0P0. Mirena IUD inserted 5 months ago<br>IUD removed by self yesterday - "just slipped out" easily without discomfort, entire device intact with strings - brought it along with her.<br>Option of replacement with new Mirena provided. Did not want to continue and wished to change over to OCP.<br><br>Reflection:<br>Expulsion or displacement of the device is the most common cause of IUD failure. There is an overall risk of expulsion of about 5%. It is more likely to occur during menstruation and the highest risk is within the first year of use. There is no evidence that expulsion is more likely in nulliparous women, although some limited evidence suggests expulsions are higher in 14-19 year olds compared to older women. |
| 15. | [redacted] | 14 | Emergency contraception and consent to treatment | 14 year old girl accompanied by older sister (who is currently 13 weeks pregnant)<br>First time sexually active 2 day ago. Unprotected vaginal intercourse with partner of the same age. Consentual. HEADSS assessment done - no concerns.<br>Has regular periods, currently in third week of period.<br>Urine pregnancy test negative and STI screening done.<br>Emergency contraceptions Levonorgestrel 1.5 mg stat given.<br>Discussed all appropriate contraception methods.<br>Fully informed consent to insertion of Implanon today. Gillick competent<br>Proceeded with insertion of implanon. Clinical follow up arranged for 1 week<br>Condoms given and safe sexual practices advised<br><br>Reflection:<br>Consent to medical treatment<br>- Under 18yrs<br>• >or= 14 yrs can give own consent to treatment under section 49 of NSW Minors (property and contracts) Act and the health practitioner will have a defence against any action for assault. The child must still meet criteria to be competent to provide consent. It is still preferable to obtain consent also from a parent.<br>• Gillick competence test, after an English judgement Gillick vs West Norfolk and Wisbech Area Health Authority (1986), also known as Frazer ruling after Judge Frazer – held there is no fixed age below 18 where a young person can be deemed competent to consent to treatment as maturity is acquired over time and varies from one person to another. Relates to providing contraception to girl under 14 yrs, where the health practitioner must consider whether the girl understands the contraceptive advice; can be persuaded to inform her parents; is likely to have |

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| | | | | sex with or without contraception; her mental or physical health is at risk if she doesn't receive contraceptive advice; it is in her best interest to receive the contraceptive advice or treatment without parental consent. |
| 16. | [redacted] | 34 | Contraception in overweight patients | 34 yo. RMP. Requesting repeat script for OCP. Nil medical condition with no chronic medications or allergies. Smoker - 20 per day. On examination BMI = 38.<br>Discussed increased risk of VTE and arterial vascular disease. Will return to see myself again next week for insertion of Mirena IUD.<br><br>Reflection:<br><br>A BMI greater than 35 is UKMEC 3 (risks outhweigh the benefits). In addition, she is also a smoker (UKMEC 2). I've carefully explained to her that her risk of VTE or arterial vascular disease is too high for her to continue using the OCP. LNG-IUDs are UKMEC 1. I've explained that this method would be much safer. She appreciated the advice and found the long term reversable IUD very convenient. She returned the week after and had her Mirena fitted without any complication. |
| 17. | [redacted] | 16 | Contraception in HIV positive adolescent | 16 yo. HIV positive; mother-to-child transmission. Currently on Genvoya (TAF/FTC/EVG/Cobi). History of poor complience. Single tablet regimen to increase complience . Planning to become sexually active in the near future. Contraceptive options discussed, including barrier methods, COC and LARCs. Agrees that a LARC would be ideal contraception (set and forget). Decided to have Implanon inserted. Safe sexual practices discussed and advised to use condoms in addition to Implanon to decrease risk of HIV transmission.<br><br>Reflection:<br>Drug-drug interactions were checked utelising the University of Liverpool website. Potential weak interaction with very low quality of evidence: Coadministration with a levonorgestrel progestogen-only implant has not been studied. Levonorgestrel is metabolized by CYP3A4 and is glucuronidated to a minor extent; coadministration is predicted to increase levonorgestrel concentrations. Based on studies with norethisterone used as a progestogen only pill, the contraceptive efficacy of a levonorgestrel progestogen-only implant is unlikely to be compromised by Genvoya. In addition, an analysis of 570 HIV-infected women in Swaziland using levonorgestrel implants and lopinavir/ritonavir based antiretroviral regimens suggested that lopinavir/ritonavir may not impair the efficacy of levonorgestrel implant. |
| 18. | [redacted] | 26 | Emergency contraception approximately 100 hours after unprotected sexual intercourse | 26 yo. No regular male partner. Not on any contraception. Presented approximately 100 hours post UPSI. Day 13 of her cycle. No known medical conditions. No chronic medications and no allergies. STI screening done and UPT negative. BMI = 22. Was given Ulipristal acetate (UPA).<br><br>Reflection: |

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| | | | | Data from non-randomised trials suggest that the failure rate for use of the Cu-IUD as EC is considerably lower than 1%, however, due to time constraints our clinic does not offer routine Cu-IUD as EC.<br>The efficacy of LNG has been demonstrated up to 72 hours after UPSI.<br>The efficacy of UPA has been demonstrated up to 120 hours after UPSI and there is no apparent decline in efficacy within that time period.<br>If UPA was received within 0-24h following UPSI: the risk of pregnancy was reduced by almost two-thirds compared to LNG; within 0-72h: as effective as LNG; and within 0-120h: halved the risk of becoming pregnant compared with LNG (Glasier et al. 2010, p. 559).<br>Use of UPA more than once per cycle or if there has been another episode of UPSI outside the treatment window (>120 hours) is not recommended.<br>Future contraception discussed: will start COC after 5 days. |
| 19. | [redacted] | 22 | Quickstart OCP | 22 yo. No regular male partner. Not currently on any contraception. Requesting to start on COCP. No medical conditions, no chronic medications, no allergies, no contraindication for COCP. Non-smoker. BMI 20. Day 10 of normal 28 day menstrual cycle. No UPSI since start of this cycle. Commenced on Ethinylestradiol 30 mcg, levonorgestrel 150 mcg, to start with active tablets today. Will use condoms persistantly for at least one week to prevent pregnancy. Aware that COCP does not prevent STIs.<br><br>Reflection:<br>Quick starting is the term used to describe immediate initiation of a contraceptive method at the time a woman requests it rather than waiting for the start of the next natural menstrual period. If a hormonal method of contraception is quick started, it may not be immediately effective and additional contraceptive precautions (barrier or abstinence) are often required until the new method becomes effective. Barrier methods of contraception may be started at any time. Healthcare practitioners can offer quick start of any method of contraception at any time in the menstrual cycle if it is reasonably certain that a woman is not pregnant or at risk of pregnancy from recent UPSI. Pregnancy in this case was reasonably excluded due to the absence of symptoms or signs of pregnancy, a negative UPT as well as the fact that she has not had intercourse since the start of her last normal menstrual period. |
| 20. | [redacted] | 25 | Medical termination of pregnancy | 25 yo G4 P 3<br>unplanned pregnancy<br>for MTOP- medical and psychosocial reecommendation<br>counselling offered<br>independent, informed decision; no coercion<br>support perosn is partner<br>lives within 30 minutes of Hospital<br>Blood goup: O neg |

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| | | | | intruaterine gestation confirmed < 63 days<br>STI screen neg<br>Med Hx- nil<br>Medciations- nil<br>Allergies - nil<br>explained medication- mechanism and side effects<br>informed and written consent obrtained<br><br>Reflection.<br>explained risk of failure 2%<br>explained risk of RPOC 3 %<br>explained risk of haemorrhage 1 in 500 - 1 in 1000<br>explained risk of infection<br>written aftercare instructions provided with clinic contact details<br>home preg test provided to do after 4 weeks<br>letter to ED provided to client with instruction<br>contact details confirmed - consents to SMS in 1 week<br>agress to contact clinic with result of preg test in 4 weeks<br>discussed contraception: will return to clinic after 6 weeks for Mirena IUD insertion<br>TREATMENT:<br>MS-2-Step as per instructions<br>Anti D administered. Left deltoid |
| 21. | [redacted] | 27 | Changing from COCP to NuvaRing | 27 yo. RMP 4 years. G2P2. Currently on COCP. Recently started missing too many pills due to busy lifestyle. Heard from friend about NuvaRing. Day 2 of normal cycle today. No medical conditions, no chronic medications, no allergies. Non smoker. Social alcohol use. BP 124/74, BMI 24. Normal pap smear within two years. Declines STI screen due to monogamous relationship. No contra-indications.<br><br>Reflection:<br>NuvaRing (etonogestrel 11.7 mg (120 mcg/24 hours), ethinylestradiol 2.7 mg) is a combined vaginal ring that is placed in the vagina for 3 weeks and then removed and discarded. The woman has a 7 day hormone-free week before a new ring is inserted. Nuvaring is 91% effective with typical use and 99.7% effective with perfect use. If changing from a COC; insert ring the day after you take your last pill (on any day of your cycle). Additional contraception is not required. |
| 22. | [redacted] | 33 | Premenstrual syndrome | 33 yo. RMP 8 years. G3P2M1. Implanon in situ for past 18 months. Normal pap smear 6 months ago. Complains of mood changes and irritability leading up to periods. Has been a life-long problem but recently became more troublesome. Leading to increased tension in the relationship. No history of depression or anxiety. DASS 21 all within normal values. No medical problems, no |

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| | | | | chronic medical conditions and no allergies.<br><br>Reflection:<br>Premenstrual syndrome (PMS) is the cyclic occurrence of symptoms (including mood or behaviour changes and cognitive disturbances) during the luteal phase of the menstrual cycle. Symptoms begin up to 14 days before, and resolve within 3 days of, the beginning of a period.<br>A good clinical approach include the following:<br>Establish cyclic nature of symptoms by encouraging the patient to keep a diary (for at least 2 cycles) of symptoms in relation to menstruation. If not clearly cyclic, consider other causes, eg depression.<br>Lifestyle changes, eg diet, exercise or rearrangement of workload, may help (can start while patient completes diary).<br>Drug choice<br>Clinical trials of drug treatment demonstrate a large placebo response, which suggests that counselling may often be more effective than drug therapy alone.<br>COCs (monophasic) may be used for mild-to-moderate symptoms although evidence is limited.<br>Extended cycles may be used in some cases depending on response. |
| 23. | [redacted] | 24 | Contraception during the postpartum period | 24yo. RMP for 4 years. G1P1, 2 weeks post partum. Breastfeeding. No known medical problems, no chronic medications and no allergies. No problems with breastfeeding. Had normal pap smear pre-conception. Baby doing very well. Wants to discuss contraception and would like to continue with breastfeeding. Contraceptive options were discussed and she was given a script for the progestogen-only pill (POP).<br><br>Reflection:<br>Contraception is not required before 21 days after delivery, however, the benefits of early initiation usually outweight the teoretical risks, particularly for woman at high risk of an early repeat pregnancy. POP can be initiated without restriction any time postpartum. COC < 6 weeks postnatal is UKMEC 4 and therefore contra-indicated |
| 24. | [redacted] | 36 | Vasectomy discussion | 36 yo male. Married for 12 years. Has 3 children with his wife. Wife had difficulties with multiple different contraceptive methods. He is requesting referral for vasectomy. No medical conditions, no chronic medications, no allergies, no previous surgery.<br><br>Reflection:<br>Vasectomy is a permanent male method of contraception and is 99.85 - 99.9% effective. It is associated with a low rate of complications and sexual function remains unchanged. Reversal can be difficult with no guarantee. It takes approximately 3 months to become effective and alternative contraception is required until a semen analysis confirms the absence of sperm. Semen analysis should be performed at 12 weeks and after a minimum of 20 ejaculations to check that there are |

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| | | | | no sperm present in the ejaculate. A systematic review of 56 studies reported the time to achieve azoospermia was variable, but more than 80% of men were azoospermic after 3 months and 20 ejaculations. The decision to have a vasectomy is a man's alone and does not require consent from a partner. |
| 25. | [redacted] | 52 | Peri-menopausal use of Mirena IUD | 52 yo, RMP, married for 30 years. G4P4. Presented today to have her Mirena IUD replaced; current Mirena inserted 5 years ago. Amenorrhoea since Mirena insertion. No post coital bleeding, no spotting, pap smear and mammogram normal 3 months ago. PMH: hypertension, hypercholesterolaemia. Meds: ramipril 10 mg daily and rosuvastatin 20 mg daily. No allergies.<br><br>Reflection:<br>Women having an LNG-IUD inserted for contraception at 45 or more years may retain the device until menopause if they are amenorrhoeic. The device can be retained for a maximum of 7 years in women who continue to bleed. Advice on stopping contraception for a woman aged 50 years and over using LNG-IUD and who is amenorrhoeic:<br>Amenorrhoeic for 12 months and more:<br>- check 2 x FSH levels at least 6 weeks apart and if both are > 30 IU/L advise that contraception is only required for another 12 months<br>or<br>- continue until 55 years and older. |
| 26. | [redacted] | 28 | Changing from DMPA to COC | 28 yo. No regular partner. G1P0T1. Current contraception DMPA. Last injection 16 weeks ago. UPSI last night. Requesting EC and to change over to COCP. No medical conditions, no chronic medications, no allergies. Smoker - 5 per day. Social alcohol use. BP 114/71, BMI 21.<br><br>Reflection:<br>Smoker < 35 years = UKMEC 2.<br>Levonorgestrel 1.5mg given for EC. Quick start Microgynon ED 150/30. Advised to use condoms for 7 days and consider home pregnancy test at 3 weeks. |
| 27. | [redacted] | 18 | Post TOP contraception | 18 yo. Casual male partners. Not on any contraception. Was given mifepristone this morning to start termination and will be taking misoprostol tomorrow as advised. Presents for implanon insertion. STI screening done during TOP work up and received treatment for chlamydia. No known medical conditions, no chronic medications, no allergies. All contraceptive options discussed and would like to continue with Implanon. Fully educated on implanon and written informed consent obtained. Implanon inserted. Follow up appointment in 1 week and repeat pregnancy test in 4 weeks post MTOP.<br><br>Reflection:<br>All methods of contracetpion except an IUD can be initiated immediately after a medical |

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| | | | | termination. It is appropriate to insert Implanon or give a DMPA injection at the time of taking mifepristone. There is a teoretical concern that same day initiation of these contraceptives may interfere with the progestogen-blocking effect of mifepristone, however this is not supported by current evidence. |
| 28. | [redacted] | 21 | COC and Migraine with aura | 21 yo. RMP for 4 weeks. G0P0. Using condoms for contraception. Requesting a script for COC. On history: migraine with aura (most recent migraine about 7 weeks ago). Uses propranolol for migraine prophylaxis and sumatriptan for acute episodes. Smokes 25 per day. No other medical conditions, no other medications, allergic to penicillin (rash). Contraceptive options discussed and advised against COCP in her case. Chose to have implanon inserted and will return next week for insertion. STI screening requested. See next week for insertion.<br><br>Reflection:<br>Migraine with aura is UKMEC 4 for COCP, and UKMEC 2 for Implanon. COCP is contraindicated in her case. Smoking is UKMEC 2 for COCP.<br>Use of COCP with migraine with aura is an unacceptable health risk unless the woman has had no episodes for more than 5 years. If the last episode was more than 5 years aog the risks usually still outweigh the benefits (UKMEC 3), but can be considere on an individual basis. For women with migraine who use COCP the odds of ischaemic stroke are increased 2-4 times compared to non-users with migraine (mostly with aura) and 6-14 times compared with non-users without migraine with aura, although migraine is poorly defined in the studies.<br>I have also strongly advised this lady to quit smoking. |
| 29. | [redacted] | 17 | IRREGULAR BLEEDING ON IMPLANON | 17 yo, no regular sexual partner. No condom use. Implanon in situ for 2 months. Requesting removal due to unacceptible irregular bleeding. On questioning, only mild spotting, but unpredictable timing, only lasts a day or two. Has not been on any other form of contraception in the past. No known medical conditions, regular medications or allergies. Non smoker, normal BMI. STI screening requested today.<br><br>Reflection:<br>Explained to her that approximately 1/2 of women with frequent or prolonged bleeding will improve after the first three months. Gave her the option of taking the COCP continuously for 3 months, in addition to keeping the implanon intact. Decided to wait and see what bleeding pattern does over the next month or two and will return to trial COCP if problem ongoing. |
| 30. | [redacted] | 31 | Benign breast lesion and COC | 31 yo. RMP. Nulliparous. Currently on Microgynon ED (levonorgestrel 150 mcg, ethinylestradiol 30 mcg). Recently diagnosed with fibroadenoma of the right breast. Was concerned about the safety of COC in the presence of fibroadenoma. No other medical conditions, no chronic medications and no allergies. Pap smear up to date. Non smoker. No contra-indications to COC. BP 122/81. BMI 26. Reassured her that COC is safe to continue in the presence of a benign breast lesion. |

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| | | | | Reflection:<br>Up to one in six (15%) of women have a fibroadenoma at some time in their life. Fibroadenomas account for about 12% of all symptomatic breast masses. Fibroadenomas are most common in women aged 20 to 40 with a peak incidence in the 21–25 year age group. Fewer than 5% occur in women over the age of 50 years. The cause of fibroadenomas is unknown, however, hormonal factors are thought to be important as fibroadenomas are known to fluctuate during the menstrual cycle and during pregnancy. Fibroadenomas can be solitary or multiple, palpable or impalpable. Benign breast conditions are UKMEC 1 for COC. |
| 31. | [redacted] | 23 | Amenorrhoea | 23 yo. No regular male partners. Sexually active, no current contraception. Used to use DMPA, but has not had an injection for > 12 months. Used to be amenorrhoeic while on DMPA, but periods have returned about 4 months after her last injection. Now concerned after realising that she hasn't had a period in 3 months. Did home pregnancy test that was negative and requesting "blood test" for pregnancy.<br>G0P0. No known medical conditions, no medications, no allergies. Been suffering from insomnia for the past few months. Busy with work and study. Does regular exercise and has a healthy diet. Reports 3 kg of unintentional weight loss. No symptoms of pregnancy. PT in office negative. BP 131/89 HR 96. Clinical examination unremarkable. Normal genital examination and pap smear performed.<br>Further investigations ordered: FSH, LH, prolactin, TFT, pelvic USS, B-hCG.<br>Returned one week later to discuss results. All normal, apart from suppressed TSH levels and elevated Free T4 levels, confirming the diagnosis of hyperthyroidism.<br><br>Reflection:<br>This case provided me with the chance to review my approach to investigating secondary amenorrhoea. By having a good understanding of the menstrual cycle and a good systematic approach for investigating menstrual irregularities, I was able to diagnose this patient with the correct cause of her amenorrhoea. I have referred her to an endocrinologist. |
| 32. | [redacted] | 21 | Skin rash while on Microgynon ED 150/30 | 21 yo. No regular male partner. G0P0. Started on Microgynon ED (levonorgestrel 150 mcg, ethinylestradiol 30 mcg) 6 months ago. Since then noticed darkening of the skin on her cheek bones. She Googled her symptoms and is concerned about melasma. No known medical conditions, no medication other than OCP, no allergies.<br>Examination confirms symmetrical hyperpigmentation over the mandibular areas, in keeping with the diagnosis of melasma.<br><br>Reflection:<br>I have explained to her that the use of COCPs has been associated with melasma and have suggested that she trials a change to a non-hormonal contraceptive. She was interested in trialing |

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| | | | | the copper IUD. I have given her a printout of alternative contraception options as well as a brochure on the copper IUD and advised her to book an appointment for the insertion of the copper IUD if she wishes to proceed. She has already came off the COCP since her Google search and will be using condoms for contraception in the meantime. I have further advised on sun protection and have explained that it may resolve spontaneously within a few months. She is very concerend about the cosmetic end result and requested a referral to a dermatologist, which I provided her with. |
| 33. | [redacted] | 37 | PCOS and fertility | 37 yo, G0P0. Initially presented with oligomenorrhea (cycle >35 days) on the background of being overweight (BMI 36). After thorough investigation, the diagnosis of PCOS was made and she presents today to discuss the results.<br>She has never been pregnant and really would like a family in the future. I have explained the diagnosis and provided her with written information. Screening for depression and anxiety was done using the DASS21 and is suggestive of moderate depression. I have also advised lifestyle modifications and discussed weight loss. I have referred her to a fertility specialist for further management, as well as to a psychologist to address her depressive symtpoms. She will return to see me in two weeks.<br><br>Reflection:<br>The diagnosis of PCOS is made when two or more of the Rotterdam diagnostic criteria are met; these criteria are:<br>1. Oligo- or anovulation<br>2. Clinical and/or biochemical hyperandrogenism<br>3. Polycystic ovaries on ultrasound (and exclusion of other aetiologies)<br><br>PCOS has an association with depression and screening is recommended for all women with PCOS. Cardiovascular risk factors and weight management should be addressed.<br>The three factors placing this lady at risk of infertility are PCOS, age > 30 and BMI > 30. While I will be working with her to address her weight and provide mental health support, early referral to a fertility specialist is indicated. |
| 34. | [redacted] | 23 | Quick start DMPA | 23 yo backpacker. No regular male partner. G0P0. ECP 2 months ago. Presented today wanting to start DMPA injections. Thinks she is currently in the third week of her current cycle. Has had UPSI since start on cycle. UPT negative today. STI screen requested today.<br><br>Reflection:<br>DMPA can be given on the day the woman chooses the method or if she presents ofr a repeat injection more than 14 weeks after her last injection. Although an early prenancy may not be able to be excluded with a pregnancy test. DMPA can be given immediately if a levonorgestrel emergency contraceptive pill is used but a delay of 5 days is required after administration of |

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| | | | | ulipristal acetate (UPA) because of the effect of DMPA on the effeciveness of the UPA. If prengnacy is excluded at time of injection advise the woman to use condoms for 7 days while waiting for the DMPA to become effective. |
| 35. | [redacted] | 21 | Missed COCP | 21 yo. No regular male partners. G0P0. Uses Microgynon 30. Has been away on a diving boat for the weekend and forgot to take her OCP along. Missed her pill for 3 days. Very concerned regarding risk of pregnancy. Has had UPSI during the 3 days of missed pills.<br><br>Reflection:<br>General principles: A pill up to 48 hours since last pill was taken is considered a late pill (not a missed pill). A pill over 48 hours since last pill was taken is a missed pill. In this young lady's case case, she was roughly 96 hours late. She was advised to take the most recent due pill as soon as possible and to discard any previously missed pills. She will continue to take the pill ath the usual time and use condoms for the next 7 consecutive days. Even though she was less than 120 hours late, she still requested the EC because she was not 100% sure of the timing. I proceeded to provide the EC. |
| 36. | [redacted] | 44 | Recent TIA while on DMPA | 44 yo, RMP G3P2T1. Has been using DMPA for the past 5 years with no side effects. Came in today for her next injection. PMH: hypertension, T2DM, dyslipidaemia. Meds: Ramipril 10 mg daily, Metformin 1g bd, Atorvastatin 80 mg daily. On examination BP 139/94, BMI 38. On further history she advised that she had been admitted to hospital 4 months ago with a TIA. Her diabetes is currently subobtimally controlled.<br><br>Reflection:<br>DMPA is UKMEC 3 for both initiation and continuation in arterial vascular disease, meaning that the risks outwight the advantages of using this method. There is a theoretical concern that the hypo-oestrogenic effect of DMPA may reduce high-density lipoprotein (HDL) cholesterol levels and therefore increasing her risk of arterial vascular disease further. I have advise her or alternative contraceptive options, including Cu-IUD (UKMEC 1), Mirena and POP (both UKMEC 2). She decided to return next week for a Mirena IUD insertion. |
| 37. | [redacted] | 39 | Contraception consultation after recent diagnosis of breast cancer (BRCA positive) | 39 yo, RMP, nulliparous. Recent diagnosis of BRCA-positive breast cancer. About to commence treatment which will be including bilateral mastectomies, chemo- and radiation therapy. Will also be started on Tamoxifen. Needs to be on reliable contraception during cancer treatment. Current contraception OCP. No other medical conditions. No current medication until diagnosis of breast cancer. No allergies. BP 114/75, BMI 22.<br><br>Reflection:<br>All hormonal contraceptives for women with current breast cancer are UKMEC 4. The LNG-IUD decreases the risk of endometrial polyps in tamoxifen users and can be considered on an |

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| | | | | individual basis in consultation with treating specialists. This lady decided to use a Cu-IUD and will return tomorrow for insertion. Her serum B-hCG is negative and she has an excellent complience history on her OCP. |
| 38. | [redacted] | 26 | Vomiting after UPA EC | 26 yo. No regular male partner. No contraception. G2P0T2. Presented earlier today for EC, 4 days after UPSI and was given Ulipristal (UPA). She phoned to advise that she vomited as soon as she got back home.<br><br>Reflection:<br>UPA is significantly more effective than LNG-EC, preventing more pregnancies at 24, 72 and 120 hours after unprotected intercourse. UPA 30 mcg is given as a single dose within 120 hours of UPSI. The dose of UPA should be repeated if vomiting occurs within 3 hours of administration. This lady experienced vomiting within the first hour of administration and was asked to return to our clinic. She was given an ondansetron 4 mg wafer, follwed by another dose of UPA 15 mins after. |
| 39. | [redacted] | 26 | Failed MTOP | MTOP - 68 days' gestation, 3 weeks ago. Has 3 young children including a 15mo boy with cerebral palsy who requires extra care. Has had minimal bleeding since MTOP. Presented today with ongoing symptoms of pregnancy. USS today shows pregnancy of 13 weeks gestation. Referred to O&G for STOP.<br><br>Reflection:<br>In 2% of cases, pregnancy may continue following a MTOP. Due to reports of foetal abnormality in pregncncies exposed to misoprostol, in these pregnancies surgical termination is strongly recommended. A LNG-IUD was inserted during the time of the STOP. |
| 40. | [redacted] | 34 | EC after missed POP | 34 yo. RMP. G2P2. History of migraine with aura and therefore on POP. Pap smears up to date and normal. Been taking POP for the past 2 years and aware of management of missed POP. Has run out of her script and therefore missed 4 doses. Has had UPSI during the time. Given LNG-EC. Discussed Implanon as alternative, but she's usually very good with her dosing.<br><br>Reflection:<br>A POP is considered missed if it is more than 3 hours late. She was advised to restart her POP as soon as she filled the script. Continue to take POP at usual time.<br>With typical use the POP is 91% effective and with perfect use 99.7%. Compared to the COC, the POP is considered to have vulnerable effectiveness and is probably much less forgiving when pills are taken late or erratically. Strict adherence to taking a pill at the same time each day is essential for maximum contraceptive effectiveness with only a 3-hour window for late pills. |

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| 41. | [redacted] | 42 | Commencing Direct Acting Antivirals (DAAs) for the treatment of chornic hepatitis C in a women on COC | 42 yo. RMP. G4P3T1. Currently on levonorgestrel 150 mcg, ethinylestradiol 30 mcg for contraception. BMI 24. PMH: Chronic hepatitis C with no cirrhosis, depression, past history of drug and alcohol dependence. Meds: escitalopram, about to commence Epclusa (Sofosbuvir/Velpatasvir) for treatment of HCV, genotype 3 with no cirrhosis. Was told by a friend that she would need to stop all her other medications.<br><br>Reflection:<br>To continue on her COC, her age of 42 would be UKMEC 2 and therefore, in itself not a contra-indication for COC continuation. Depression and chronic HCV without cirrhosis are both UKMEC 1. There are no drug-drug interactions. I have explained to her that there are no contra-indications to continue on her current treatment of COC as well as her SSRI and reassured her that there should be no problems commencing her DAAs. |
| 42. | [redacted] | 28 | Antiretrovirals and contraception. | 28 yo, RMP, also HIV positive and on treatment. Visiting from South Africa and not Medicare eligible. PMH: HIV, diagnosed at age 22. Well controlled on Atripla (TDF,FTC,EFV). No other medical conditions, medications or allergies. Presented today because she is due to have her DMPA injection. Due to travelling and potential difficutlies in getting to see a doctor or nurse for administration, she asked if she could change to COC.<br><br>Reflection:<br>Efavirenz has multiple potential drug-drug interactions with commonly used contraceptive methods. Efavirenz is contra-indicated in the use with levonorgestrel and etonogestrel (Implanon) due to reducing their contraceptive efficacies. There is a potential interaction with estradiols, also potentially decresing contraceptive efficacy. I have explained this to her and discussed alternative options, including Mirena and copper-IUDs. She decided to continue with DMPA but left with further information on IUD for further consideration. She will be travelling through Australia and I have given her further advise regarding access to services. |
| 43. | [redacted] | 21 | Fertility preservation in transgender woman | 21 yo MTF transgender. Lifelong history of gender dysphoria. Been engaged with psychology for the past 11 months.<br>H: lives with mum, dad and younger sister - none aware of GD<br>E: completed yr 12. Works in family business as forklift operator<br>A: moderate physical activity<br>D: past history of depression<br>D: no drugs. Social alcohol use (has "self medicated" in the past)<br>S: has had suicidal thoughts as teenager, but no attempts and no history of self harm.<br>S: single. Relationships on and off. Attracted to woman<br>PMH: 1. HOCM - has implanted defib 2. Depression/Anxiety<br>Meds: Mirtazapine, Diazepam prn. Allergies none. Non-smoker<br>FHx: - mother * MI in 2012, * recently diagnosed with breast cancer |

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| | | | | Still confused regarding transitioning<br>- does not feel that they can do it at the current moment due to still living at home<br>- thinks that dad will have a hard time to come to terms<br>Treatment goals at present:<br>- decreased body and facial hair<br>- broader hips<br>- higher pitch voice<br>Had questions regarding T-blockers<br>Not too keen on starting oestradiol at present<br>Would like to have sperm frozen for the future - referral to fertility specialist given.<br>Would like surgery in the future for facial feminisation and higher pitch voice<br>Also altimately considering bottom surgery<br>Expectations, risks, pros and cons discussed<br>Baseline bloods today<br>RV 1 week<br><br>Reflection:<br>In transgender women, research suggests that prolonged estrogen exposure of the testes has been associated with testicular damage. Restoration of spermatogenesis following extended estrogen treatment, however, has not been well studied. The most successful option for fertility preservation for transgender women is cryopreservation of sperm prior to initiation of hormone therapy. |
| 44. | [redacted] | 24 | Deep, impalpable Implanon | 24 yo, RMP. Referred to our clinic from her GP due to deep, impalpable Implanon. Is due to have it taken out and would like to have it replaced with a new one. G0P0, pap smears up to date with GP. No medical conditions, no chronic medications and no allergies.<br><br>Relection:<br>Our clinic is one of the referral points in the area for difficult removal of implants. I have performed a bedside ultrasounds scan and have identified the position of the Implanon. After written informed consent, I proceeded to remove her old Implanon without any complication and have replaced it with a new one. She was due to have her Implanon replaced this month and therefore did not require any additional contraception during the change over of Implanons. |
| 45. | [redacted] | 18 | Acne while on Implanon | 18 yo. No regular male partners. Implanon inserted 9 months ago. Has since had worsening in acne and is also "fed up" with unpredictable bleeding. Requesting to have Implanon removed and to commence on COC. Has not been on the COC before. No medical conditions, chronic medications or allergies. BP 114/62, BMI 20. Non smoker. No contra-indications for COC.<br><br>Reflection: |

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| | | | | Implanon may worsen acne in some women. Approximately 35% of women using Implanon may experience infrequent bleeding or spotting per 90 days. I have continued to remove her Implanon today. After thorough education on the use of COC, I provided a prescription for Yasmin (drospirenone 3 mg, ethinylestradiol 30 mcg). Drospirenone has anti-androgenic effects which improves acne. |
| 46. | [redacted] | 28 | Restarting COC | 28 yo. RMP. Backpacking from Canada. Would like to start COC. G0P0. Have been taking a break from all forms of hormonal contraception for the past 7 years (no medical reason for this). Has been using spermacide and condoms for contraception. Would like to restart COC, had no problems while on it in the past. On day 2 of current, normal period. No known medical conditions, no chronic medications and no allergies. No contra-indication for COC. BP 113/72, BMI 20.<br><br>Reflection:<br>Spermicidal products are not available in Australia. Spermicide alone is estimated to have a failure rate of 18% with perfect use and 28% with typical use. It is not recommended as a contraceptive. Contraceptive effect would be immediate due to starting it within the first 5 days of her cycle. |
| 47. | [redacted] | 37 | Referral for tubal ligation following MTOP | 37 yo, husband of 13 years. G4P3T1. Used to be on COC until unplanned pregnancy. MTOP 4 weeks ago with no complication. Aware of other forms of long acting reversible contraception (LARCs). Has already made the decision along with her husband that they do not want any more children. Made the final decision herself. No medical conditions. No chronic medications. No allergies. Fully educated on risks and benefits and wishes to proceed. Referral for tubal ligation sent off.<br><br>Reflection:<br>Tubal ligation is a permanent form of contraception with efficacy more than 99.5%. The cumulative failure rate of permanent female contraceptive procedures in Australia is less then 1%. |
| 48. | [redacted] | 41 | COC and hypertension | 41 yo. RMP. G3P3. Presents for a repeat script for Microgynon ED (levonorgestrel 150 mcg, ethinylestradiol 30 mcg). On further history she informed that she was diagnosed with hypertension 3 months ago by her GP and was started on Coveram (perindopril arginine 5 mg, amlodipine 5 mg). She has a family history of cardiovascular disease. No other medical conditions, no other medications and no allergies. BP 149/89. BMI 28. Non smoker. Pap smears are up to date and normal.<br><br>Reflection:<br>Controlled hypertension is UKMEC 3 (the risk outweigh the advantages of using his method). I have advised her about the risk and have discussed alternative contraception with her. She will return next week for the insertion of an Implanon implan (UKMEC 1 in hypertension without vascular disease). |

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| 49. | [redacted] | 22 | TOP discussion and referral for surgical termination | 22 yo. Recently seperated from abusive relationship and currently living at a Womans Shelter with her 18 month old daughter. Been in abusive relationship for over 1 year and last week an escalation in verbal and physical violence led to her contacting police. Police have now got a DV order on ex. Has not seen ex since and feels safe at the shelter. Continuing with pregnancy will have significant psychological and financial implications.<br>USS date: 30/10/17<br>Gestation:12 weeks 1 day<br>Baseline pregnancy blood investigations as well as STI screening done in clinic today.<br>Contraception used- nil<br>Contraception Post TOP: all I contraceptive choices discussed. Keen to try Mirena IUD.<br>Support Person - Client denies any support [redacted] States Mother is in prison and family involved in drugs etc. Came [redacted] to escape the difficult environment. Has made a friend at the shelter who she confides in.<br>No significant medical condtion<br>Nil known allergies<br>Medications: Zoloft, propanolol<br>Not currently breastfeeding<br>G2, P0<br>No prior LUSC<br>Discussed STOP specialist referral; cost; time off work; Day Hospital requirements of STOP<br>Children By Choice information provided<br>Consents to detailed SMS f/u<br>Referred to social worker; appointment this afternoon at 11:30am.<br>Children by Choice contact details given and advised they offer support with DV and sexual coercion. Also given DV contacts and support phone numbers.<br>Given referral for STOP. Will fill script for Mirena IUD and will take it along for placement at time of STOP.<br>Continuing to provide support and still seeing social worker.<br><br>Reflection:<br>Surgical curettage is generally suitable for gestations of pregnancy up to 14 weeks. If the pregnancy is between 14 and 16 weeks gestation, the procedure should only be performed by experienced practitioners. The procedure may be preceded by cervical priming. |
| 50. | [redacted] | 20 | Contraception in transgender male | 20 yo FTM transgender. Started new relationship with male partner a few months ago. Receptive vaginal intercourse. Has been using condoms for contraception. Wanting to commence testosterone therapy today. Been engaged with our service for the past 6 months. Has appropriate support. Fully consented and aware of irreversable body changes, including deepening of the voice, clitoromegaly, hair loss, amenorrhoea and fertility changes. Fully aware of need to continue with cervical cancer screening and breast cancer screening, is however planning top surgery in the |

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| | | | | near future. Have been discussing fertility preservation since first consultation 6 months ago and does not want to proceed with oocyte storage. Consented to continue with treatment (written consent in file). No medical conditions, no chronic medications, no allergies. All baseline blood and STI screening NAD. BP 111/68 BMI 22.<br>Lenghty discussion regarding possible side effects and treatment goals<br>Testosterone options discussed. Need for reliable contraception discussed and would like to start on DMPA injections today. Both DMPA and testosterone injections administered today.<br>Review in 2 weeks.<br><br>Reflection:<br>Fertility will not immediately cease when testosterone treatment is commenced. Due to the teratogenic effects of testosterone, it is imperative that transgender men having vaginal sex with other men, continue to use reliable contraceptive methods until amenorrhoea has been achieved for at least two months. |