February 4, 2013
TODAY'S HEALTH FOR THE EMPOWERED WOMAN

GYNECOLOGIC EMERGENCIES

It is an irrefutable fact that access to medical care is becoming more of a problem in the United States and especially in Central New York where unemployment is staggering. This results in a large number of people with no health insurance stressing an environment that has a doctor shortage that is projected to get worse as reimbursement issues and medical malpractice problems drive doctors to early retirement or to leave New York State. That being said, the Urgent Care Centers and Emergency Departments are overwhelmed with patients, some with problems that are emergent and others, not. It has always been difficult to define what an "emergency" is. In general a condition that the patient feels is an emergency must be treated as such. Given the access problem to physicians' offices these emergencies rise astronomically during weekends and holidays, after office hours, and when a patient has no personal physician. Since this column is devoted to gynecology, I will limit the discussion to gynecologic emergencies that are most common, recognizing that the list is not all inclusive. By far, the most frequent gynecologic emergency that comes to the emergency room is abnormal bleeding. Only the patient can tell you if the bleeding is heavy or not. Immediately blood pressure and other vital signs must be taken to rule out shock and lab work to include what the current blood count is. This will enable the physician, nurse practitioner or physician assistant to triage the patient according to acuity and to determine if the workup need be done instantly or in a certain time frame that allows other patients with more severe problems such as heart attack and trauma to be seen first. The most frequent reasons for emergency room visits for women with bleeding are miscarriage in which bleeding can be severe and sometimes life threatening; menstrual irregularities; ectopic pregnancy (pregnancy in the fallopian tube) that causes bleeding and pain; previously undiagnosed cancer of the female genital tract (vagina, cervix, or uterus) ; and trauma secondary to accidental injuries or rape. Above all the examination in the emergency room must include palpation of the abdomen and a pelvic exam even if the examiner is not experienced in this part of the exam. Failure to do so cannot even begin to come to any differential diagnosis as to the cause of the bleeding. Pelvic sonography and CT scan are adjuncts to the diagnosis and not a substitute for physical exam. When all of these modalities are done the emergency provider will either : 1.) treat the underlying cause and send home with follow-up to a gynecologist ; 2.) refer to the gynecologist on call to determine the next treatment, or 3.) refer and prepare the patient for surgery .

The next most common gynecologic emergency is pain either acute or chronic. In addition to vital signs and lab work as mentioned above, a detailed history should include whether the pain started suddenly or gradually; where the pain is located; does the pain radiate?; is it constant or intermittent?; a description of the pain (sharp, crampy, knifelike, etc); on a scale of 0-10 where does the degree of pain fall; is there associated nausea or vomiting?; are there any alleviating or aggravating symptoms? Again, CT scan and sonogram are useful adjuncts in the diagnosis but not a substitute for pelvic and

abdominal exam and adequate history. Frequent diagnoses include ovarian masses and cysts, gallbladder disease, appendicitis, diverticulosis, urinary tract infections, kidney stones, cancer, flu like symptoms, constipation, food poisoning and infections of the tubes and ovaries. A word here on ovarian cysts. My office and the offices of my gynecologic colleagues across the nation are inundated with referrals for cysts diagnosed by ct scans that are less than 3cm in size (roughly a little over an inch). The NORMAL ovary is 3cm by 2 cm by 2cm or the size of a large almond. Cysts are fluid filled by definition, not malignant and something detected by CT scan that is smaller than a normal ovary is NOT the cause of acute pain and does not warrant a cancer workup. The amount of anxiety created in these women is unprecedented. If the above workup is done in the emergency department then an appropriate timely referral to a gynecologist can be made OR the determination can be made that the presenting condition needs admission to the hospital for medical treatment or surgical consultation by an urologist, general surgeon or gynecologist. Patients presenting to the urgent care center or emergency department must understand that evaluation and triage are important so that the very most sick are taken care of first and that long waits do not represent a non caring attitude by the providers, rather the opposite.