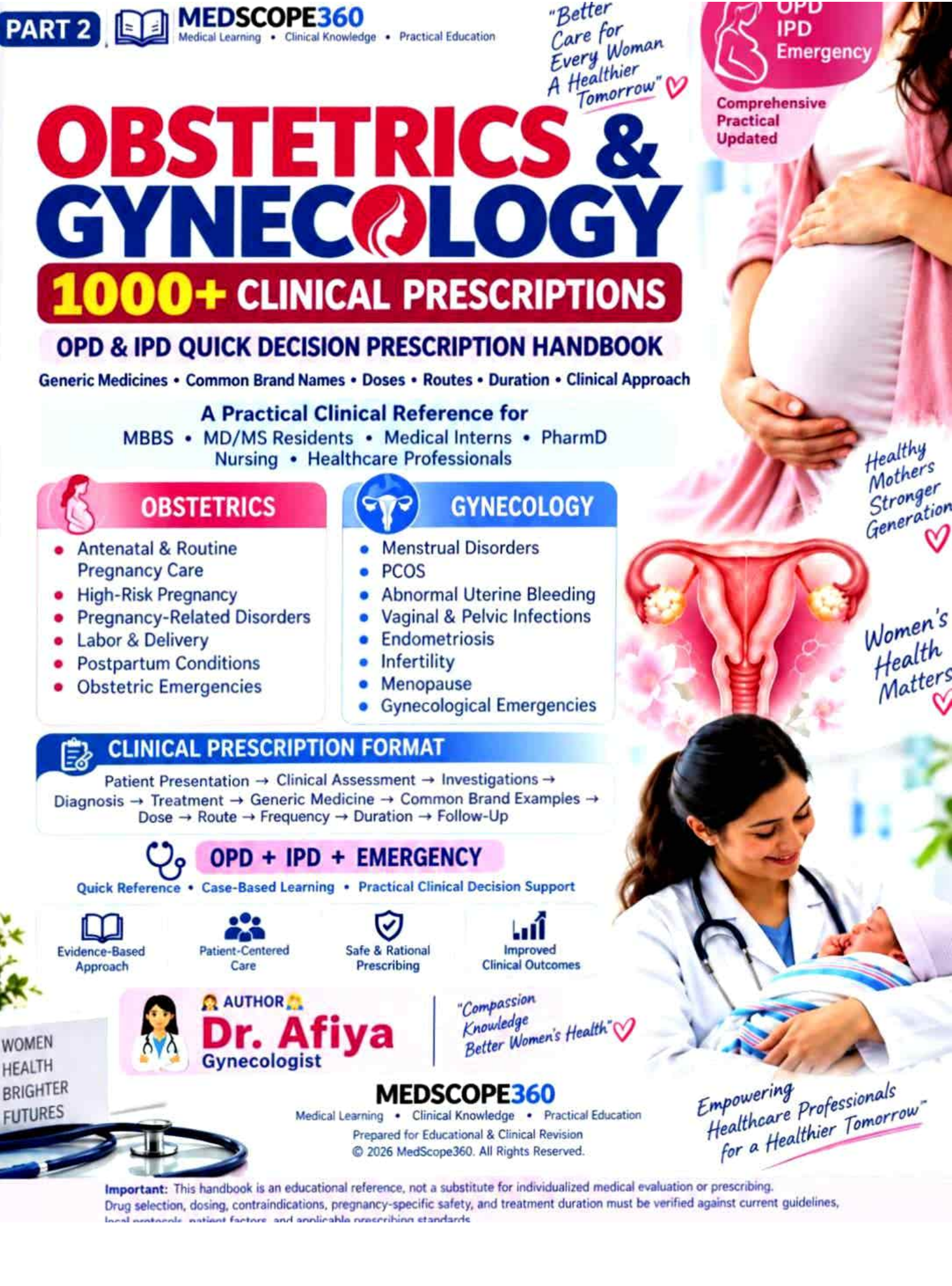




PART 2 | **MEDSCOPE360**
Medical Learning • Clinical Knowledge • Practical Education

OBSTETRICS & GYNECOLOGY
1000+ CLINICAL PRESCRIPTIONS
OPD & IPD QUICK DECISION PRESCRIPTION HANDBOOK
Generic Medicines • Common Brand Names • Doses • Routes • Duration • Clinical Approach

A Practical Clinical Reference for
MBBS • MD/MS Residents • Medical Interns • PharmD
Nursing • Healthcare Professionals

OBSTETRICS

- Antenatal & Routine Pregnancy Care
- High-Risk Pregnancy
- Pregnancy-Related Disorders
- Labor & Delivery
- Postpartum Conditions
- Obstetric Emergencies

GYNECOLOGY

- Menstrual Disorders
- PCOS
- Abnormal Uterine Bleeding
- Vaginal & Pelvic Infections
- Endometriosis
- Infertility
- Menopause
- Gynecological Emergencies

CLINICAL PRESCRIPTION FORMAT
Patient Presentation → Clinical Assessment → Investigations →
Diagnosis → Treatment → Generic Medicine → Common Brand Examples →
Dose → Route → Frequency → Duration → Follow-Up

OPD + IPD + EMERGENCY
Quick Reference • Case-Based Learning • Practical Clinical Decision Support

Evidence-Based Approach • **Patient-Centered Care** • **Safe & Rational Prescribing** • **Improved Clinical Outcomes**

WOMEN HEALTH BRIGHTER FUTURES

Dr. Afiya
Gynecologist

MEDSCOPE360
Medical Learning • Clinical Knowledge • Practical Education
Prepared for Educational & Clinical Revision
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Important: This handbook is an educational reference, not a substitute for individualized medical evaluation or prescribing. Drug selection, dosing, contraindications, pregnancy-specific safety, and treatment duration must be verified against current guidelines, local protocols, patient factors, and applicable prescribing standards.

"Better Care for Every Woman A Healthier Tomorrow" ♥

OPD IPD Emergency
Comprehensive Practical Updated

Healthy Mothers Stronger Generation ♥

Women's Health Matters ♥

"Compassion Knowledge Better Women's Health" ♥

Empowering Healthcare Professionals for a Healthier Tomorrow

CHRONIC PELVIC PAIN

(Pain > 6 months)

1. Clinical Symptoms

- 1) Dull, aching or cramping lower abdominal pain for > 6 months
- 2) Cyclic or non-cyclic pain (may be constant)
- 3) Dyspareunia (pain during intercourse)
- 4) Dysmenorrhea (painful periods)
- 5) Pelvic heaviness or pressure
- 6) Bowel symptoms (constipation, diarrhea, IBS)
- 7) Urinary symptoms (frequency, urgency, dysuria)
- 8) Infertility or difficulty conceiving
- 9) Fatigue, sleep disturbance, mood changes



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2. Red Flags (Urgent Evaluation)

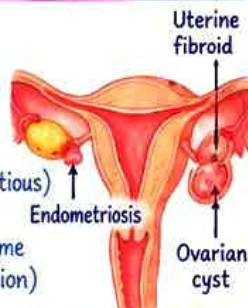
- 1) Severe or progressively worsening pain
- 2) Postmenopausal bleeding
- 3) Unexplained weight loss
- 4) Fever or signs of infection
- 5) Pelvic mass on examination
- 6) New onset pain in postmenopausal woman
- 7) Symptoms of cancer (early satiety, abdominal distension, ascites)
- 8) Acute abdomen features (guarding, rigidity)
- 9) Neurological deficits or severe bowel/bladder dysfunction



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3. Provisional Diagnoses (Common Causes)

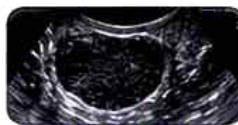
- 1) Endometriosis
- 2) Adenomyosis
- 3) Chronic pelvic inflammatory disease (PID)
- 4) Uterine fibroids
- 5) Ovarian pathology (endometrioma, cysts)
- 6) Pelvic adhesions (post-surgical or post-infectious)
- 7) Irritable bowel syndrome (IBS)
- 8) Interstitial cystitis / painful bladder syndrome
- 9) Musculoskeletal pain (pelvic floor dysfunction)
- 10) Chronic pelvic congestion syndrome
- 11) Neuropathic pain
- 12) Psychological factors (depression, anxiety)



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4. Investigations

- 1) CBC, ESR, CRP
- 2) Urine routine and culture
- 3) Pregnancy test (β -hCG)
- 4) Transvaginal ultrasound (TVS)
- 5) Pelvic MRI (if needed)
- 6) Diagnostic laparoscopy (gold standard for endometriosis)
- 7) STI screening (NAAT for chlamydia, gonorrhea)
- 8) CA-125 (if ovarian malignancy suspected)
- 9) Colonoscopy / cystoscopy (if bowel or bladder symptoms)
- 10) Laparoscopy with biopsy (if diagnosis unclear)



Endometrioma on ultrasound

5. Differential Diagnosis

- 1) IBS / IBD
- 2) UTI / interstitial cystitis
- 3) Appendiceal pathology
- 4) Hernia
- 5) Musculoskeletal pain
- 6) Ovarian cancer
- 7) Neuropathic pain
- 8) Psychological causes

6. Treatment Ladder

First Line (Initial Management)

- 1) Identify and treat underlying cause
- 2) NSAIDs for pain (e.g. ibuprofen, naproxen)
- 3) Hormonal therapy (combined OCPs / progestins)
- 4) Lifestyle modification (exercise, diet, stress management)
- 5) Pelvic floor physiotherapy
- 6) Counseling and psychological support



Combined OCPs

Second Line (If inadequate response)

- 1) GnRH agonists / antagonists (for endometriosis)
- 2) Danazol (selected cases)
- 3) Levonorgestrel IUS (for adenomyosis/heavy bleeding)
- 4) Neuropathic pain agents (gabapentin, amitriptyline)
- 5) Pelvic floor trigger point therapy



Levonorgestrel IUS

Third Line (Definitive / Advanced Management)

- 1) Laparoscopic excision of endometriosis / adhesiolysis
- 2) Myomectomy / hysterectomy (selected cases)
- 3) Oophorectomy (in refractory cases)
- 4) Multidisciplinary pain management (pain specialist, gynecologist, physiotherapist, psychologist)



Laparoscopic treatment

7. Common Medicines (Generic, Brand & Dose)

Medicine	Dose (Adult)	Route	Frequency	Common Brands
Ibuprofen	400-600 mg	PO	8 hourly	Brufen, Ibugesic
Naproxen	250-500 mg	PO	12 hourly	Naprosyn, Naprox
Combined OCP (EE + Levonorgestrel)	1 tab	PO	Daily	Mala D, Ovral
Medroxyprogesterone	10 mg	PO	Daily	Provera
Levonorgestrel IUS	52 mg	Intrauterine	Every 5 years	Mirena
GnRH agonist (Leuprolide)	3.75 mg	IM	Monthly	Lucrin, Leuplin
Amitriptyline	10-25 mg	PO	Nightly	Tryptomer, Amitone
Gabapentin	300 mg	PO	8 hourly	Gabantin, Neurontin
Dienogest	2 mg	PO	Daily	Visanne

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8. OPD Plan (For Stable Patients)

- 1) Detailed history and pelvic examination
- 2) Baseline investigations and imaging (TVS)
- 3) Start NSAIDs and/or hormonal therapy
- 4) Lifestyle advice (diet, exercise, weight control)
- 5) Treat associated conditions (IBS, UTI, thyroid etc.)
- 6) Arrange follow-up in 6-12 weeks



9. IPD Plan (Indications)

- 1) Severe pain not controlled on OPD therapy
- 2) Suspected acute complication (torsion, rupture, abscess)
- 3) Need for surgical management (laparoscopy / myomectomy)
- 4) Severe anemia or heavy bleeding
- 5) Need for intensive pain management or multidisciplinary care



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10. Follow-up

- 1) Review at 6-12 weeks after treatment initiation
- 2) Assess pain control using pain score (e.g. VAS)
- 3) Monitor side effects of medications
- 4) Repeat imaging if symptoms persist
- 5) Reassess fertility plans and psychological well-being

11. Discharge Criteria (After IPD)

- 1) Pain controlled with oral medications
- 2) Hemodynamically stable
- 3) No evidence of active infection
- 4) Able to tolerate oral diet
- 5) Follow-up appointment arranged

POSTOPERATIVE PELVIC ABSCESS (After Gynecological Surgery)

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1. Clinical Symptoms

- 1) Fever with chills (usually 4-14 days post-surgery)
- 2) Lower abdominal / pelvic pain
- 3) Abdominal distension / bloating
- 4) Nausea, vomiting, loss of appetite
- 5) Vaginal discharge (purulent / foul smelling)
- 6) Urinary symptoms (frequency, dysuria)
- 7) Pain on bowel movements / constipation
- 8) Malaise, fatigue, general weakness



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2. Red Flags (Emergency Escalation)

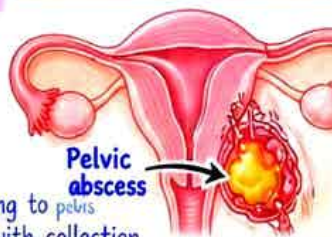
- 1) Persistent high fever ($> 38.5^{\circ}\text{C}$)
- 2) Tachycardia (HR $> 120/\text{min}$)
- 3) Hypotension (SBP $< 90 \text{ mmHg}$)
- 4) Signs of sepsis (confusion, altered sensorium)
- 5) Severe or increasing abdominal pain
- 6) Signs of generalized peritonitis (rigid abdomen)
- 7) Inability to tolerate oral intake
- 8) Worsening leukocytosis / raised lactate
- 9) Failure to respond to initial antibiotics
- 10) Suspected rupture or widespread infection



→ Requires urgent hospital assessment, imaging and possible surgical / interventional drainage.

3. Provisional Diagnoses

- 1) Postoperative pelvic abscess
- 2) Infected hematoma / seroma
- 3) Pelvic cellulitis
- 4) Pelvic peritonitis
- 5) Urinary tract infection
- 6) Intra-abdominal abscess extending to pelvis
- 7) Wound / vaginal cuff infection with collection
- 8) Other causes: bowel injury, anastomotic leak, PID



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4. Investigations

- 1) CBC, ESR, CRP
- 2) Blood cultures (if febrile / sepsis)
- 3) Urine analysis and culture
- 4) Vaginal/cervical swab for culture
- 5) Ultrasound (TVS / transabdominal)
- 6) Contrast CT abdomen-pelvis (gold standard)
- 7) Baseline renal and liver function tests
- 8) Serum lactate (if sepsis suspected)
- 9) Consider culture from drained pus
- 10) Additional tests if indicated (β -hCG, STI screening)



Pelvic abscess on CT scan

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5. Differential Diagnoses

- | | |
|--------------------------------|------------------------------------|
| 1) Postoperative hematoma | 6) Bowel injury / anastomotic leak |
| 2) Seroma | 7) Pelvic peritonitis |
| 3) Pelvic cellulitis | 8) Endometriosis (if pre-existing) |
| 4) Urinary tract infection | 9) Ovarian cyst / torsion |
| 5) Deep pelvic vein thrombosis | 10) Tubo-ovarian abscess (PID) |

6. Treatment Ladder

First Line (Initial Management)

- 1) Hospital admission and close monitoring
- 2) IV broad spectrum antibiotics (e.g. ceftriaxone + metronidazole or piperacillin-tazobactam as per local protocol)
- 3) Adequate analgesia and IV fluids
- 4) Bowel rest (if ileus suspected)
- 5) Thromboprophylaxis (e.g. enoxaparin)



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Second Line (If no improvement / large abscess)

- 1) Image-guided percutaneous drainage (USG / CT guided)
- 2) Continue IV antibiotics (culture guided)
- 3) Consider transvaginal or transabdominal drainage
- 4) Individualize based on size, location and clinical response



Image guided drainage

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Third Line (Definitive / Advanced Management)

- 1) Surgical exploration and abscess drainage (laparoscopy / laparotomy)
- 2) Source control (e.g. repair of bowel injury, remove infected material)
- 3) Management of complications (sepsis, peritonitis, fistula)
- 4) Multidisciplinary approach (gynecologist, general surgeon, radiologist, intensivist)

7. Common Medicines (Generic, Brand & Dose)

Medicine	Dose (Adult)	Route	Frequency	Common Brands
Ceftriaxone	1-2 g	IV	Once daily	Monocef, Taxim
Metronidazole	500 mg	IV	8 hourly	Metrogyl, Flagyl
Piperacillin-Tazobactam	4.5 g	IV	6-8 hourly	Tazocin
Amikacin (if severe sepsis)	15 mg/kg	IV	Once daily	Amikacin
Paracetamol	500-1000 mg	PO/IV	6-8 hourly	Dolo, Calpol
Ibuprofen	400 mg	PO	8 hourly	Brufen, Ibugesic
Enoxaparin (prophylaxis)	40 mg	SC	Once daily	Clexane

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8. OPD Plan (For stable, small abscess or after discharge)

- 1) Review clinical symptoms and vitals
- 2) Continue oral antibiotics (as per culture sensitivity)
- 3) Oral analgesics and supportive care
- 4) Repeat ultrasound to document resolution
- 5) Advice rest, nutrition and avoid heavy work
- 6) Counsel regarding warning signs for immediate return



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9. IPD Plan (For moderate to severe cases)

- 1) Admit and monitor vitals, urine output, clinical status
- 2) IV broad spectrum antibiotics (modify as per culture)
- 3) Imaging (USG / CT) and drainage if indicated
- 4) Analgesia, IV fluids, electrolyte correction
- 5) Repeat labs and follow up cultures
- 6) Surgical consultation if no response or complications
- 7) Monitor for sepsis, ileus, or other postoperative complications



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10. Follow-up

- 1) Clinical review at 1-2 weeks after discharge
- 2) Repeat imaging (USG/CT) to confirm resolution
- 3) Assess wound healing and any persistent symptoms
- 4) Monitor for recurrence or complications
- 5) Long term follow up for underlying cause if identified

11. Discharge Criteria

- 1) Afebrile for > 48 hours
- 2) Hemodynamically stable
- 3) Pain controlled with oral medication
- 4) Tolerating oral diet
- 5) Improving inflammatory markers
- 6) No unresolved complications
- 7) Follow-up arranged

Note: Antibiotic choice and duration should be guided by culture and sensitivity, local protocol and individual patient factors. Pregnancy status, allergies, renal and hepatic function must be considered. Large or complicated abscesses may require drainage and multidisciplinary management.

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PROLONGED PERIODS (MENORRHAGIA)

(Bleeding > 7 days or excessive flow)

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1. Clinical Symptoms

- 1) Menstrual bleeding lasting > 7 days
- 2) Heavy flow (soaking pads/tampons frequently)
- 3) Passing large clots
- 4) Fatigue, weakness, dizziness
- 5) Lower abdominal pain / cramping
- 6) Pallor, breathlessness (due to anemia)
- 7) Interference with daily activities
- 8) Associated symptoms (e.g. irregular cycles, infertility, pelvic pain depending on cause)



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2. Red Flags (Urgent Evaluation)

- 1) Hemodynamic instability (SBP < 90 mmHg)
- 2) Tachycardia (HR > 120/min)
- 3) Severe anemia (Hb < 7 g/dL or symptomatic)
- 4) Active heavy bleeding (soaking ≥ 2 pads/hour)
- 5) Pregnancy with bleeding (rule out miscarriage/ectopic pregnancy)
- 6) Postmenopausal woman with bleeding
- 7) History of bleeding disorder or on anticoagulants
- 8) Severe abdominal pain / signs of acute abdomen
- 9) Syncope or recurrent dizziness



3. Provisional Diagnoses (Common Causes)

- 1) Anovulatory bleeding (adolescents, perimenopause, PCOS)
- 2) Uterine fibroids
- 3) Adenomyosis
- 4) Endometrial polyps
- 5) Endometrial hyperplasia / malignancy
- 6) Endometritis (infection)
- 7) Coagulopathy (e.g. von Willebrand disease)
- 8) Thyroid disorders (hypo / hyperthyroidism)
- 9) PCOS / hormonal imbalance
- 10) IUCD related bleeding (especially Cu-IUD)
- 11) Gestational causes (miscarriage, ectopic)
- 12) Drug induced (anticoagulants, hormone therapy)



Heavy menstrual bleeding

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4. Investigations

- 1) CBC, hemoglobin, platelet count
- 2) Serum ferritin, iron profile
- 3) β-hCG (to rule out pregnancy)
- 4) Thyroid function tests (TSH, FT4)
- 5) Coagulation profile (PT, aPTT) if indicated
- 6) Transvaginal ultrasound (TVS)
- 7) Endometrial sampling (if > 40 yrs or risk factors)
- 8) PAP smear (as per age)
- 9) Hormonal profile (FSH, LH, prolactin) if indicated
- 10) Additional tests: LFT, KFT, bleeding disorder workup



TVS showing endometrial thickening

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5. Differential Diagnoses

- 1) Pregnancy related bleeding (miscarriage, ectopic)
- 2) Acute pelvic inflammatory disease
- 3) Endometrial or cervical malignancy
- 4) Coagulopathy / thrombocytopenia
- 5) Thyroid dysfunction
- 6) IUCD related bleeding
- 7) Drug induced bleeding
- 8) Cervical polyp or cervicitis
- 9) Systemic illness (liver / renal disease)

6. Treatment Ladder

First Line (Initial Management)

- 1) Assess hemodynamic status and severity of bleeding
- 2) Reassurance and counseling
- 3) NSAIDs for pain and to reduce bleeding (e.g. mefenamic acid)
- 4) Tranexamic acid during menses
- 5) Combined oral contraceptive pills (if no contraindication)
- 6) Treat underlying cause (e.g. thyroid, infection)
- 7) Iron supplementation for anemia



Combined OCPs

Second Line (If persistent or recurrent)

- 1) Progestin therapy (oral / injectable / LNG-IUS)
- 2) Tranexamic acid (oral/IV)
- 3) NSAIDs (if not already used)
- 4) Levonorgestrel intrauterine system (LNG-IUS)
- 5) Endometrial ablation (selected cases, no future fertility)



LNG-IUS

Third Line (Refractory / Specific Etiology)

- 1) Surgical management as per cause
 - Hysteroscopic polypectomy / myomectomy
 - Endometrial ablation (no future fertility)
 - Hysterectomy (definitive, for completed family or malignancy)
 - Treat coagulopathy or systemic illness appropriately



Uterine fibroid

7. Common Medicines (Generic, Brand & Dose)

Medicine	Dose (Adult)	Route	Frequency	Common Brands
Tranexamic acid	500 mg - 1 g	PO	8 hourly (during menses up to 3-5 days)	Transamin
Mefenamic acid	500 mg	PO	8 hourly (during menses)	Ponstan, Mefkind
Combined OCP (Ethinylestradiol + Levonorgestrel)	1 tab	PO	Once daily (21 days cycle)	Mala D, Ovral
Norethisterone	5 mg	PO	3 times daily (for 10-21 days)	Primolut-N
Medroxyprogesterone	10 mg	PO	1-2 times daily	Provera
Levonorgestrel IUS	52 mg	Intrauterine	Single insertion (effective 5 years)	Mirena
Iron (Ferrous sulfate)	200 mg (elemental)	PO	1-2 times daily	Fefol, Livogen
NSAIDs (Ibuprofen)	400 mg	PO	8 hourly	Brufen, Ibugesic

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8. OPD Plan (For stable patients)

- 1) Detailed history (cycle pattern, amount, medications, comorbidities)
- 2) Clinical examination (general, abdominal, pelvic)
- 3) Investigations as indicated (CBC, TVS, TSH, etc.)
- 4) Medical management (NSAIDs, tranexamic acid, hormonal therapy)
- 5) Treat underlying cause (thyroid, PCOS, infection)
- 6) Iron supplementation and diet advice
- 7) Counseling regarding lifestyle, weight control and follow-up



9. IPD Plan (For severe bleeding, anemia or failed OPD treatment)

- 1) Admit and monitor vitals, urine output
- 2) IV fluids and blood transfusion if needed
- 3) IV tranexamic acid / high dose hormonal therapy
- 4) Treat underlying cause and manage anemia
- 5) Urgent imaging (TVS/CT) and gynecology consult
- 6) Consider surgical intervention if not controlled
- 7) Monitor for complications (shock, severe anemia)



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10. Follow-up

- 1) Review at 4-6 weeks after treatment
- 2) Monitor hemoglobin and iron status
- 3) Assess response to therapy and side effects
- 4) Repeat imaging if symptoms persist
- 5) Long term management plan based on etiology
- 6) Counsel on menstrual diary and lifestyle modification

11. Discharge Criteria (After IPD)

- 1) Hemodynamically stable
- 2) Bleeding controlled
- 3) Hemoglobin stable (or improved)
- 4) Able to tolerate oral medication
- 5) No acute complications
- 6) Follow-up appointment arranged

Note: Treatment should be individualized based on age, desire for future fertility, underlying cause and comorbidities.

Exclude pregnancy and malignancy in all women with abnormal uterine bleeding. Severe bleeding or red flag symptoms require immediate hospitalization.

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BLEEDING WITH PCOS (Heavy or Prolonged Menstrual Bleeding) medscope.360

1. Clinical Symptoms

- 1) Prolonged menstrual bleeding (> 7 days)
- 2) Heavy flow (soaking pads, clots)
- 3) Irregular cycles (infrequent or frequent)
- 4) Spotting between periods
- 5) Lower abdominal pain / cramps
- 6) Symptoms of anemia (fatigue, weakness, dizziness)
- 7) Hirsutism, acne, weight gain (PCOS features)
- 8) Infertility / difficulty conceiving
- 9) Mood changes, disturbed sleep



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2. Red Flags (Emergency Escalation)

- 1) Hemodynamic instability (SBP < 90 mmHg)
- 2) Tachycardia (HR > 120/min)
- 3) Severe anemia (Hb < 7 g/dL)
- 4) Ongoing heavy bleeding (soaking ≥ 2 pads/hour)
- 5) Syncope, dizziness or altered sensorium
- 6) Pregnancy with bleeding (rule out ectopic/miscarriage)
- 7) Suspected endometrial hyperplasia or malignancy
- 8) Failure of medical therapy
- 9) Signs of acute abdomen (severe pain)



3. Provisional Diagnoses (Common Causes)

- 1) Anovulatory bleeding due to PCOS (most common)
- 2) Endometrial hyperplasia (due to unopposed estrogen)
- 3) Endometrial polyp
- 4) Thyroid dysfunction
- 5) Hyperprolactinemia
- 6) Coagulation disorders (von Willebrand disease)
- 7) Pregnancy related bleeding (miscarriage, ectopic)
- 8) Uterine fibroids / adenomyosis
- 9) Endometrial infection (endometritis)
- 10) Medication induced bleeding (anticoagulants)
- 11) Endometrial carcinoma (rare, but consider in high risk)



Polycystic ovaries
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4. Investigations

- 1) CBC, hemoglobin, platelet count
- 2) Serum ferritin, iron profile
- 3) Pregnancy test (B-hCG)
- 4) Thyroid function tests (TSH, FT4)
- 5) Serum prolactin
- 6) Hormonal profile (LH, FSH, LH/FSH ratio, androgens)
- 7) Transvaginal ultrasound (TVS)
- 8) Endometrial sampling (if abnormal ultrasound/ age > 35 yrs / risk factors)
- 9) Coagulation profile (PT, aPTT, von Willebrand factor)
- 10) HbA1c, lipid profile (PCOS metabolic evaluation)
- 11) USG to assess endometrial thickness and ovarian morphology



USG showing polycystic ovaries
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5. Differential Diagnoses

- | | |
|-------------------------------|--|
| 1) Pregnancy related bleeding | 7) Endometrial hyperplasia / carcinoma |
| 2) Thyroid disorder | 8) Coagulation disorders |
| 3) Hyperprolactinemia | 9) Chronic endometritis |
| 4) Uterine fibroids | 10) Medication induced bleeding |
| 5) Endometrial polyp | 11) Other hormonal imbalances (Cushing's syndrome, etc.) |
| 6) Adenomyosis | |

6. Treatment Ladder

First Line (Initial Management)

- 1) Hemodynamic stabilization if needed
- 2) Treat anemia (iron therapy, blood transfusion if severe)
- 3) NSAIDs for pain (e.g. mefenamic acid)
- 4) Cyclic progestins (e.g. medroxyprogesterone 10 mg OD for 10-14 days each month)
- 5) Combined oral contraceptive pills (if no contraindication)
- 6) Lifestyle modification (weight loss, exercise, diet)
- 7) Treat associated metabolic issues (insulin resistance)



Combined OCPs

Second Line (If persistent bleeding)

- 1) Higher dose progestins (medroxyprogesterone 20 mg TDS for 7 days, then taper)
- 2) Tranexamic acid (1 g TDS during heavy bleeding)
- 3) Levonorgestrel IUS (for long term control)
- 4) Metformin (for PCOS with insulin resistance)
- 5) Manage thyroid / prolactin abnormalities



Levonorgestrel IUS

Third Line (Refractory / Specific Indications)

- 1) Endometrial ablation (if completed family, no fertility desire)
- 2) Hysteroscopic polypectomy / myomectomy (if structural cause)
- 3) GnRH analogs (short term, in selected cases)
- 4) Consider hysterectomy (definitive, in refractory cases or endometrial hyperplasia/malignancy)



Endometrial polyp

7. Common Medicines (Generic, Brand & Dose)

Medicine	Dose (Adult)	Route	Frequency	Common Brands
Tranexamic acid	500 mg - 1 g	PO/IV	TDS (during heavy bleeding)	Transamin, Tazloc
Mefenamic acid	500 mg	PO	TDS	Ponstan, Mefkind
Medroxyprogesterone	10 mg	PO	OD for 10-14 days	Provera
Combined OCP (EE + Levonorgestrel)	1 tab	PO	OD	Mala D, Ovral
Levonorgestrel IUS	52 mg	Intrauterine	Effective 5 years	Mirena
Metformin	500-1000 mg	PO	BD-TDS	Glycomet, Glucophage
Iron (Ferrous sulfate)	200 mg (elemental)	PO	OD-BD	Fefol, Livogen

8. OPD Plan (For stable patients)

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- 1) Detailed history (cycle pattern, bleeding amount, associated symptoms)
- 2) Clinical examination (BMI, signs of PCOS, pallor, pelvic exam)
- 3) Baseline investigations (CBC, TVS, thyroid, prolactin, etc.)
- 4) Start medical therapy (OCPs or cyclic progestin + NSAIDs)
- 5) Lifestyle advice (weight loss, diet, exercise)
- 6) Treat metabolic comorbidities (metformin if indicated)
- 7) Follow-up in 6-12 weeks to assess response



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9. IPD Plan (For severe bleeding / anemia / failed OPD treatment)

- 1) Admit and monitor vitals, urine output
- 2) IV fluids and blood transfusion if needed
- 3) IV tranexamic acid or high dose hormonal therapy
- 4) Pain control and correction of anemia
- 5) Urgent TVS/CT if indicated
- 6) Gynecology review for possible procedural intervention
- 7) Address underlying cause and monitor for complications



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10. Follow-up

- 1) Review at 6-12 weeks
- 2) Monitor hemoglobin and iron status
- 3) Assess response to therapy and side effects
- 4) Repeat ultrasound if bleeding persists
- 5) Long term management for PCOS, fertility counseling
- 6) Lifestyle modification and weight management

11. Discharge Criteria (After IPD)

- 1) Hemodynamically stable
- 2) Bleeding controlled
- 3) Hemoglobin stable or improving
- 4) Tolerating oral medications
- 5) No acute complications
- 6) Follow-up appointment arranged

Note: Management should be individualized based on age, fertility desire, severity of bleeding and underlying cause. Exclude pregnancy and malignancy in all women with abnormal uterine bleeding. Severe bleeding or red flag symptoms require immediate hospitalization. medscope.360

POSTPARTUM AMENORRHEA

(Absence of menstruation after delivery)

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1. Clinical Symptoms

- 1) Absence of menstruation after delivery beyond expected period
(> 6 months in non-lactating,
> 12 months in lactating)
- 2) No cyclic vaginal bleeding
- 3) Breastfeeding (lactational amenorrhea)
- 4) Signs of pregnancy (nausea, breast tenderness)
- 5) Symptoms of hormonal imbalance
(weight gain, fatigue, cold intolerance)
- 6) Features of underlying cause (headache, visual changes, excessive thirst, etc.)



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2. Red Flags (Emergency Evaluation)

- 1) Severe headache or visual disturbances (pituitary apoplexy / Sheehan's syndrome)
- 2) Excessive postpartum bleeding history
- 3) Failure to lactate
- 4) Signs of pituitary dysfunction (fatigue, low BP, cold intolerance)
- 5) Symptoms suggestive of pregnancy with pain (ectopic pregnancy)
- 6) Severe hypothyroid symptoms (altered sensorium, bradycardia)
- 7) Rapid weight loss or eating disorders
- 8) Abnormal uterine bleeding when menstruation resumes



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3. Provisional Diagnoses (Common Causes)

- 1) Lactational amenorrhea (physiological)
- 2) Intrauterine pregnancy
- 3) Sheehan's syndrome (postpartum pituitary necrosis)
- 4) Hyperprolactinemia (lactation, prolactinoma)
- 5) Thyroid disorders (hypothyroidism)
- 6) Asherman's syndrome (postpartum intrauterine adhesions)
- 7) PCOS (pre-existing or unmasked)
- 8) Hypothalamic amenorrhea (stress, weight loss)
- 9) Premature ovarian insufficiency
- 10) Chronic illness / systemic disease
- 11) Drug induced (antipsychotics, antidepressants, etc.)



Pituitary gland

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4. Investigations

- 1) Urine pregnancy test (β -hCG)
- 2) Serum β -hCG (if doubt)
- 3) Serum prolactin
- 4) Thyroid function tests (TSH, FT4)
- 5) FSH, LH, estradiol (if ovarian failure suspected)
- 6) AMH (ovarian reserve, if needed)
- 7) Pelvic ultrasound (uterus, endometrium, ovaries)
- 8) MRI pituitary (if hyperprolactinemia, headaches or visual symptoms)
- 9) Hysteroscopy (if Asherman's suspected)
- 10) Other tests as indicated (CBC, metabolic profile)



Pelvic ultrasound (uterus and ovaries)

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5. Differential Diagnosis

- | | |
|---------------------------------------|------------------------------------|
| 1) Pregnancy / lactational amenorrhea | 6) PCOS |
| 2) Sheehan's syndrome | 7) Hypothalamic amenorrhea |
| 3) Hyperprolactinemia | 8) Premature ovarian insufficiency |
| 4) Hypothyroidism | 9) Chronic systemic illness |
| 5) Asherman's syndrome | 10) Drug induced amenorrhea |

6. Treatment Ladder

First Line (Initial Management)

- 1) Confirm pregnancy test and identify cause
- 2) Reassurance if lactational amenorrhea
- 3) Treat underlying cause (thyroid disorder, hyperprolactinemia etc.)
- 4) Weight management, nutrition and lifestyle modification
- 5) Counsel regarding return of menses and fertility
- 6) If not breastfeeding and no contraindication, consider hormonal therapy for cycle regulation



Lactational amenorrhea
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Second Line (If specific cause identified)

- 1) Dopamine agonists (cabergoline/bromocriptine) for hyperprolactinemia
- 2) Levothyroxine for hypothyroidism
- 3) Estrogen-progestin therapy for hypogonadotropic amenorrhea
- 4) Surgical management for Asherman's syndrome (hysteroscopic adhesiolysis)
- 5) Hormonal therapy for PCOS or ovarian insufficiency

Third Line (Refractory / Complex Cases)

- 1) Pituitary hormone replacement (in Sheehan's syndrome)
- 2) Assisted reproductive techniques if infertility
- 3) Multidisciplinary management (endocrinologist, gynecologist, fertility specialist)
- 4) Psychological support for stress related causes

7. Common Medicines (Generic, Brand & Dose)

Medicine	Dose (Adult)	Route	Frequency	Common Brands
Cabergoline	0.25-0.5 mg	PO	Twice weekly	Cabgolin, Dostinex
Bromocriptine	2.5 mg	PO	Twice daily	Parlodel
Levothyroxine	25-100 mcg	PO	Once daily (morning)	Thyronorm, Eltroxin
Combined OCP (EE + Levonorgestrel)	1 tab	PO	Once daily	Mala D, Ovral, Etinor
Medroxyprogesterone	10 mg	PO	10-14 days/month	Provera
Tranexamic acid (if abnormal bleeding)	500 mg	PO	8 hourly (max 3-5 days)	Transamin
Iron (Ferrous sulfate)	200 mg (elemental)	PO	Once or twice daily	Fefol, Livogen

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8. OPD Plan (For stable patients)

- 1) Detailed history (delivery details, lactation, cycle pattern, symptoms)
- 2) Clinical examination (general, breasts, pelvic exam)
- 3) Basic investigations (pregnancy test, TSH, prolactin, USG)
- 4) Treat identified cause
- 5) Counsel on breastfeeding, contraception and fertility plans
- 6) Lifestyle advice (nutrition, weight control, stress management)
- 7) Regular follow-up every 3-6 months



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9. IPD Plan (Indications)

- 1) Severe symptoms (headache, visual loss, shock)
- 2) Suspected Sheehan's syndrome
- 3) Abnormal uterine bleeding with hemodynamic instability
- 4) Need for dynamic endocrine testing or MRI
- 5) Surgical management (Asherman's syndrome)
- 6) Management of associated complications or severe anemia



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10. Follow-up

- 1) Review at 6-12 weeks and then 3-6 monthly
- 2) Monitor menstrual pattern and symptoms
- 3) Reassess hormonal profile if needed
- 4) Monitor side effects of medications
- 5) Counsel regarding future fertility and contraception
- 6) Long term follow-up for underlying cause

11. Discharge Criteria (After IPD)

- 1) Hemodynamically stable
- 2) Symptoms controlled
- 3) Underlying cause identified / treated
- 4) Able to tolerate oral medications
- 5) No active bleeding
- 6) Follow-up arranged with gynecologist/ endocrinologist

Note: Return of menses is usually delayed in breastfeeding women and can occur up to 12-18 months. Exclude pregnancy in all women with postpartum amenorrhea. Persistent amenorrhea beyond expected period requires evaluation for underlying endocrine, uterine or ovarian causes.

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