

[HOSPITAL / HEALTH AUTHORITY NAME]

# ACUTE GYNAECOLOGICAL EMERGENCIES PATHWAY

## Protocol 39: Rapid Stabilization, Pregnancy Exclusion, Haemorrhage Control, Early-Pregnancy Assessment, Torsion and Sepsis Recognition, Specialist Escalation, Transfer, and Safe Disposition

DRAFT FOR EMERGENCY MEDICINE, OBSTETRICS AND GYNAECOLOGY, NURSING, ANAESTHESIA / CRITICAL CARE, RADIOLOGY / ULTRASOUND, LABORATORY / BLOOD BANK, PHARMACY, SEXUAL HEALTH, MENTAL HEALTH, SAFEGUARDING, PRIMARY CARE, AND TRANSFER SERVICES

STATUS: This is a draft clinical-governance document. It must be adapted to local gynaecology, early-pregnancy, ultrasound, theatre, anaesthesia, blood-bank, laboratory, sexual-health, safeguarding, mental-health, pharmacy, referral and inter-island / tertiary-transfer capabilities. Drug concentrations, antimicrobial regimens, transfusion pathways, anti-D policy, pregnancy-loss pathways, legal requirements and specialist availability must be verified locally before implementation.

**GYNAECOLOGICAL EMERGENCY RULE: Stabilize first, determine pregnancy status early, and never allow a negative or inconclusive initial test to override dangerous physiology. Haemodynamic instability, peritonism, severe or escalating pain, major vaginal bleeding, syncope, fever with organ dysfunction, suspected ectopic rupture, adnexal torsion, tubo-ovarian abscess rupture or post-procedural injury requires immediate senior gynaecological and anaesthetic / surgical escalation.**

Document control	Details
Document owner	Emergency Department / Medical Services Directorate / Nursing Services / Clinical Governance
Clinical leads	Emergency Medicine; Obstetrics and Gynaecology; Anaesthesia / Critical Care; Radiology / Ultrasound; Haematology / Transfusion; Laboratory; Pharmacy; Sexual Health; Safeguarding
Applies to	Adolescents and adults presenting with acute pelvic or lower abdominal pain, vaginal bleeding, suspected early-pregnancy complication, acute vulval / vaginal condition, pelvic infection, adnexal emergency, post-procedural complication or other acute gynaecological concern.
Interfaces	Protocol 3 Sepsis / Shock; Protocol 17 Altered Mental Status; Protocol 24 Acute Abdominal and Flank Pain; Protocol 25 Gastrointestinal Bleeding; Protocol 28 AKI / Electrolytes; Protocol 29 Poisoning; Protocol 31 Major Trauma; Protocol 38 Obstetric and Postpartum Emergencies; Protocol 43 Safeguarding / Sexual Assault; local early-pregnancy, theatre, blood-bank and transfer policies.
Version / status	Draft 1.0 for local multidisciplinary validation
Review cycle	After any maternal or gynaecological death, delayed ectopic diagnosis, unexpected major haemorrhage, torsion-related organ loss, sepsis, medication event, transfer failure, safeguarding concern, or at least every 2 years.
Required approval	Emergency Department; Obstetrics and Gynaecology; Nursing; Anaesthesia / ICU; Radiology; Laboratory / Blood Bank; Pharmacy; Sexual Health; Safeguarding; Clinical Governance.

## 1. Purpose

To provide a standardized emergency-department pathway for rapid recognition and stabilization of acute gynaecological emergencies; early determination of pregnancy status; prompt diagnosis and treatment of haemorrhage, ectopic pregnancy, miscarriage complications, adnexal torsion, pelvic infection and acute uterine bleeding; and safe admission, transfer, follow-up and discharge.

## 2. Scope

This protocol applies from pre-alert or first contact through discharge, observation, admission, emergency surgery, critical care, specialist transfer, pregnancy-loss care, safeguarding referral or death. Later-pregnancy, intrapartum and postpartum emergencies are addressed in Protocol 38. Sexual assault forensic management is addressed in Protocol 43, while immediate medical stabilization remains within this protocol.

## 3. Core policy statements

- Every patient with actual or possible reproductive potential who presents with pelvic or abdominal pain, vaginal bleeding, collapse, syncope or unexplained shock requires prompt pregnancy assessment unless pregnancy is biologically impossible, already definitively established or the patient declines after informed discussion.
- Pregnancy status is a safety variable, not a moral judgement. Ask privately, use inclusive and non-stigmatizing language, protect confidentiality and do not delay emergency treatment while resolving uncertainty.

- An unstable patient with possible ectopic pregnancy or intra-abdominal bleeding requires immediate resuscitation and operative-capable gynaecological / surgical response. Do not delay for formal ultrasound, serial hCG, haemoglobin decline or transfer paperwork.
- Pregnancy of unknown location remains a possible ectopic pregnancy until location and outcome are established. Clinical symptoms take priority over a single hCG value or an apparently reassuring trend.
- Adnexal torsion is a time-critical surgical diagnosis. Normal arterial or venous Doppler flow does not exclude torsion, and imaging must not delay gynaecological review when clinical suspicion is high.
- Acute abnormal uterine bleeding is managed according to physiology and bleeding severity first, then pregnancy status, coagulopathy, medication exposure and PALM-COEIN causes. Medical therapy is preferred when appropriate, but unstable or refractory bleeding requires procedural source control.
- Pelvic inflammatory disease should be treated empirically when the clinical threshold is met and no more dangerous alternative explains the presentation. Pregnancy, severe illness, tubo-ovarian abscess, inability to tolerate oral therapy or uncertain diagnosis lowers the threshold for admission.
- Analgesia, antiemetics and compassionate care must not be withheld while awaiting diagnostic certainty. Reassess after treatment because symptom evolution is diagnostically important.
- Pelvic examination, transvaginal ultrasound and intimate procedures require consent, privacy, a trained chaperone, trauma-informed communication and the option to stop. Avoid repeated examinations; share findings across teams.
- Every discharge must include a documented working diagnosis, unresolved uncertainty, 24-hour return instructions, responsible follow-up service, outstanding-result plan and clear contraception / fertility / pregnancy-loss support as appropriate.

## 4. Definitions and severity framework

Term	Operational definition / response
<b>Gynaecological emergency</b>	Acute condition involving the uterus, cervix, adnexa, vagina or vulva with actual or threatened haemorrhage, sepsis, organ ischaemia, tissue necrosis, reproductive harm, severe pain or loss of physiological stability.
<b>Early pregnancy</b>	Pregnancy up to 13 completed weeks for the purposes of ectopic-pregnancy and miscarriage assessment; local services may use different operational thresholds.
<b>Pregnancy of unknown location (PUL)</b>	Positive pregnancy test with no intrauterine or extrauterine pregnancy identified on ultrasound. Manage as possible ectopic pregnancy until resolved.
<b>Major vaginal bleeding</b>	Bleeding causing haemodynamic compromise, syncope, shock index concern, rapid pad saturation, large clots, ongoing brisk flow, clinically important anaemia or need for blood / procedural control.
<b>Suspected adnexal torsion</b>	Sudden or intermittent unilateral pelvic pain, often with nausea / vomiting and adnexal enlargement or tenderness. Requires urgent gynaecological assessment and usually diagnostic laparoscopy.
<b>Pelvic inflammatory disease (PID)</b>	Clinical syndrome of ascending genital-tract infection. Empiric treatment is appropriate with pelvic / lower abdominal pain plus cervical motion, uterine or adnexal tenderness when no better cause is identified.
<b>Tubo-ovarian abscess (TOA)</b>	Complex inflammatory adnexal mass associated with PID; rupture or septic physiology is a surgical / interventional emergency.
<b>Acute abnormal uterine bleeding (AUB)</b>	Bleeding from the uterine corpus that is abnormal in volume, regularity or timing and requires immediate intervention to prevent further blood loss.
<b>Post-abortion / post-procedural complication</b>	Haemorrhage, retained tissue, infection, uterine or cervical injury, perforation, ongoing pregnancy or ectopic pregnancy after medical or procedural pregnancy termination or uterine instrumentation.

## 5. Roles and accountability

Role	Minimum responsibility
<b>Triage / receiving nurse</b>	Identify major bleeding, collapse, severe pain, fever / sepsis, pregnancy possibility, recent pregnancy or procedure; obtain complete observations, pain score, point-of-care glucose and immediate senior escalation.
<b>ED clinician</b>	Lead ABCDE, resuscitation, pregnancy testing, haemorrhage and sepsis treatment, differential diagnosis, appropriate examination, imaging and time-critical gynaecology / surgical consultation.
<b>Gynaecology clinician</b>	Lead early-pregnancy interpretation, torsion / adnexal assessment,

Role	Minimum responsibility
	AUB treatment plan, pelvic infection management, operative decision, uterine evacuation, drainage and specialist follow-up.
Anaesthesia / critical care	Support airway, major haemorrhage, procedural analgesia / anaesthesia, vasopressors, invasive monitoring, perioperative stabilization and critical-care transfer.
Radiology / ultrasound	Provide urgent transvaginal / transabdominal ultrasound and Doppler, identify haemoperitoneum, adnexal pathology and alternative diagnoses, and communicate critical findings directly.
Blood bank / laboratory	Prioritize pregnancy test / hCG, full blood count, coagulation, crossmatch, chemistry and microbiology; provide emergency blood and support massive-haemorrhage activation.
Pharmacy	Verify emergency medication, antimicrobial, hormonal, methotrexate, anti-D and reversal pathways; ensure high-risk medication availability and safe administration.
Sexual health / safeguarding	Support STI testing, partner management, contraception, coercion / violence / assault concerns, adolescent confidentiality and safe referral.
Transfer coordinator	Confirm accepting specialist, transport capability, blood / medication needs, monitoring, escort, documentation and contingency plan.
Team leader / scribe	Assign roles, use closed-loop communication, record times, bleeding, medications, response, consultations and decisions; initiate debrief / incident review when indicated.

## 6. Pre-alert, preparation, and triage

Pre-alert / triage question	Operational significance
Is the patient unstable, fainting, confused, breathless or actively haemorrhaging?	Immediate resuscitation area, senior ED and gynaecology activation, two large-bore IVs, crossmatch, haemorrhage equipment and operative / transfer readiness.
Could the patient be pregnant, and when was the last normal menstrual period?	Triggers immediate urine / serum pregnancy testing, ectopic precautions and pregnancy-safe imaging / medication decisions.
Is pain sudden, unilateral, severe, intermittent or associated with vomiting?	Raises adnexal torsion, cyst rupture, ectopic rupture or renal / surgical causes; requires urgent reassessment and ultrasound / specialist review.
Is there shoulder-tip pain, rectal pressure, syncope or collapse?	Suggests intraperitoneal bleeding from ectopic pregnancy or cyst rupture even when visible vaginal bleeding is limited.
How much bleeding, how quickly, and are there clots or tissue?	Guides haemorrhage activation, pregnancy-loss / AUB pathway, need for speculum examination and source control.
Is there fever, rigors, offensive discharge, recent uterine procedure, IUD insertion or abortion?	Raises PID, TOA, septic miscarriage / abortion, endometritis, retained tissue or perforation.
Is the patient postmenopausal or older than 40 with a new vulval / Bartholin mass?	Raises malignancy risk and need for urgent specialist evaluation / biopsy pathway.
Is there anticoagulation, bleeding disorder, fertility treatment or recent ovarian stimulation?	Raises major bleeding, thrombosis, ectopic / heterotopic pregnancy and ovarian hyperstimulation risks.
Is there sexual assault, coercion, trafficking, domestic violence or inability to speak privately?	Triggers immediate safety, safeguarding and forensic pathway while minimizing repeated intimate examination.

**TRIAGE OVERRIDE: Collapse, shock, peritonism, severe or escalating pain, major bleeding, positive pregnancy test with pain / tenderness, suspected torsion, fever with organ dysfunction, ruptured TOA, post-procedural injury or inability to maintain the airway bypasses routine waiting and moves directly to monitored resuscitation care.**

## 7. The first 10 minutes

1. Activate senior ED and gynaecology support; add anaesthesia / critical care, theatre, blood bank, surgery, radiology and transfer services according to physiology and likely source.
2. Perform ABCDE. Give oxygen for hypoxaemia or critical illness; attach ECG, pulse oximetry and frequent BP; check temperature, mental status and glucose.

3. For shock or major bleeding, insert two large-bore IV lines, send full blood count, group / crossmatch, coagulation including fibrinogen when haemorrhage is severe, electrolytes, renal / liver profile, lactate / blood gas and quantitative hCG when relevant. Activate the major-haemorrhage pathway early.
4. Obtain a point-of-care pregnancy test immediately when pregnancy is possible. A negative urine test does not exclude very early pregnancy when suspicion remains; send serum hCG.
5. Provide IV / oral analgesia and antiemetic treatment. Keep nil by mouth when surgery, anaesthesia or procedural sedation is possible.
6. Perform focused abdominal examination for peritonism, distension, mass and haemorrhage. Pelvic / speculum examination is performed only when it will change immediate management and after consent, chaperone and preparation.
7. Use bedside ultrasound for free fluid, gross uterine / adnexal pathology and pregnancy assessment when skilled staff are available, but do not let a nondiagnostic scan delay definitive care.
8. Treat suspected sepsis promptly with cultures when feasible, broad-spectrum antibiotics and source-control escalation. Treat symptomatic haemorrhage with warmed blood products according to local protocol.
9. If torsion is suspected, call gynaecology now, document symptom onset, avoid false reassurance from Doppler flow and prepare for urgent laparoscopy / transfer.
10. Explain priorities, preserve privacy, ask about preferred terminology and support person, and document exact times, findings and response.

## 8. Focused assessment and investigations

### 8.1 History and examination

Domain	Minimum assessment
<b>Bleeding history</b>	Onset, duration, pad / tampon / cup use, flooding, clots / tissue, intermenstrual or postcoital bleeding, baseline cycle, prior episodes, anaemia symptoms and medication / anticoagulant exposure.
<b>Pain history</b>	Onset, side, sudden versus gradual, intermittent torsion-like episodes, radiation, shoulder tip / rectal pressure, relation to menses / intercourse, vomiting, urinary and gastrointestinal symptoms.
<b>Pregnancy context</b>	Last normal menstrual period, contraception, fertility treatment, prior ectopic / miscarriage, tubal surgery, IUD / implant, recent pregnancy / abortion / procedure and pregnancy intention when relevant.
<b>Infection / sexual history</b>	Fever, rigors, discharge, dyspareunia, STI exposure, recent instrumentation, partner symptoms, antibiotic use, sexual assault / coercion and safeguarding concerns. Ask privately.
<b>Medical risk</b>	Bleeding disorder, liver / renal disease, thrombosis, migraine with aura, smoking, hormone use, immunosuppression, malignancy, medications and allergies.
<b>Abdominal examination</b>	Tenderness, guarding / rebound, distension, palpable mass, surgical scars, flank / hernia findings and non-gynaecological causes.
<b>Pelvic examination</b>	External bleeding / trauma / lesions / swelling; speculum for source, cervical os, tissue, foreign body and discharge; bimanual assessment only when needed for cervical motion, uterine / adnexal tenderness or mass. Avoid repeated exams.
<b>Physiological trend</b>	Serial pulse, BP, shock index, capillary refill, mental status, urine output, temperature, pain and cumulative bleeding. A normal initial haemoglobin does not exclude acute blood loss.

### 8.2 Targeted testing and imaging

- Pregnancy test is the first diagnostic branch for most reproductive-age presentations. Obtain quantitative serum hCG for positive / equivocal tests, suspected very early pregnancy, PUL, possible ectopic pregnancy or follow-up planning.
- Core tests in significant bleeding or illness: full blood count, group and screen / crossmatch, renal and liver profile, coagulation, fibrinogen when major haemorrhage, lactate / blood gas, urinalysis and ECG as clinically indicated.
- Use transvaginal and transabdominal pelvic ultrasound with adnexal Doppler as first-line imaging when a gynaecological cause is suspected. Transvaginal ultrasound requires consent; transabdominal ultrasound may supplement or substitute with acknowledged limitations.
- Do not use a single hCG value to locate a pregnancy, and do not diagnose nonviability from one early ultrasound unless accepted criteria are unequivocally met and local specialist review confirms them.
- Use CT abdomen / pelvis with IV contrast when a non-gynaecological or life-threatening alternative is likely, when ultrasound is nondiagnostic in a seriously ill patient, or when perforation / abscess / haemorrhage mapping is needed. Pregnancy does not justify withholding necessary imaging.

- Collect NAAT for gonorrhoea and chlamydia, vaginal tests according to local practice, HIV / syphilis screening and cultures where infection is suspected, but do not delay empiric PID / sepsis treatment.
- Consider ferritin and bleeding-disorder evaluation in recurrent heavy menstrual bleeding, especially adolescents, but emergency stabilization and bleeding control take priority.
- Pathology testing of passed tissue or uterine contents follows local pregnancy-loss, molar-pregnancy and medicolegal policy; do not assume that tissue passage confirms an intrauterine pregnancy.

## 9. Early-pregnancy pain, bleeding, and pregnancy of unknown location

Clinical state	Emergency-department response
<b>Unstable / peritonitic / significant haemoperitoneum</b>	Resuscitate as ruptured ectopic or other internal haemorrhage; activate gynaecology, anaesthesia, blood bank and theatre / transfer. Do not delay for serial hCG or formal imaging when definitive care is required.
<b>Positive pregnancy test + pain / pelvic tenderness</b>	Urgent gynaecological / early-pregnancy assessment and transvaginal ultrasound. Ectopic pregnancy must be excluded even without known risk factors.
<b>Intrauterine pregnancy of uncertain viability</b>	Use validated ultrasound criteria. When criteria are not definitive, arrange repeat specialist ultrasound after the recommended interval rather than making a premature miscarriage diagnosis.
<b>Pregnancy of unknown location</b>	Treat as possible ectopic pregnancy. Symptoms outweigh hCG. Obtain two quantitative hCG measurements about 48 hours apart under a named follow-up service and provide 24-hour return access.
<b>Apparent complete miscarriage without prior confirmed IUP</b>	Do not close the episode as complete miscarriage until ectopic pregnancy / PUL has been excluded through follow-up.
<b>Threatened miscarriage, stable viable IUP</b>	Provide analgesia, safety-netting and early-pregnancy follow-up. Progesterone use, where indicated by history and local policy, is specialist / protocol directed.
<b>RhD-negative early pregnancy</b>	Apply the locally ratified anti-D policy. NICE 2026 does not recommend anti-D through 11+6 weeks for ectopic pregnancy, miscarriage or threatened miscarriage; it recommends at least 250 IU at 12+0 to 12+6 weeks for medical or surgical management and consideration for heavy / recurrent threatened-miscarriage bleeding. Local national policy may differ.

**PUL SAFETY RULE: A reassuring hCG trend, low hCG or empty uterus never removes the need for immediate reassessment when pain, bleeding, syncope or physiological status worsens.**

## 10. Ectopic pregnancy

Situation	Priority management
<b>Suspected rupture / instability</b>	Immediate operative-capable response. Resuscitate with blood-product support, keep nil by mouth, obtain consent when feasible and transfer only if the required surgery is unavailable and transport risk is acceptable.
<b>Confirmed or highly suspected unruptured ectopic</b>	Senior gynaecology determines expectant, methotrexate or surgical management using symptoms, ultrasound, hCG, haemodynamic stability, follow-up reliability, fertility considerations and contraindications.
<b>Methotrexate consideration</b>	Do not administer in the ED without a confirmed specialist plan, reliable follow-up, baseline full blood count / renal / liver tests, exclusion of significant contraindications and counselling that rupture remains possible during treatment.
<b>Heterotopic pregnancy risk</b>	An intrauterine pregnancy does not exclude a simultaneous ectopic pregnancy, particularly after assisted reproduction or when adnexal findings / free fluid are present.
<b>Cervical, caesarean-scar, interstitial or other non-tubal ectopic</b>	Urgent specialist management; haemorrhage risk may be high and treatment differs from routine tubal ectopic pregnancy.
<b>After treatment</b>	Provide written rupture precautions, 24-hour contact, hCG / ultrasound schedule, medication restrictions, fertility / grief support and clear ownership of follow-up.

## 11. Miscarriage, incomplete abortion, and post-abortion complications

Presentation	Emergency response
Major bleeding / shock	ABCDE, large-bore access, crossmatch, warmed blood products and urgent gynaecological source control. Consider retained tissue, cervical / uterine injury, coagulopathy and ectopic pregnancy.
Septic miscarriage / abortion	Immediate broad-spectrum IV antibiotics, cultures when feasible, lactate / organ assessment, urgent uterine evacuation / source control and critical-care support. Do not delay treatment for ultrasound.
Retained products / incomplete miscarriage	Assess bleeding, pain, infection and ultrasound findings. Stable patients may be managed expectantly, medically or surgically by shared specialist decision; unstable, infected or persistently bleeding patients require urgent evacuation.
Post-procedural perforation / visceral injury	Suspect with severe or persistent abdominal pain, peritonism, shock, shoulder pain, fever, unexpected bleeding or inability to account for instruments / tissue. Urgent gynaecology / surgery, imaging when stable and operative evaluation as indicated.
Ongoing pregnancy after medical abortion	Confirm with specialist assessment and ultrasound / hCG pathway. Discuss options non-judgementally and ensure ectopic pregnancy has been considered.
Pregnancy loss care	Offer clear explanation, pain relief, privacy, opportunity for support, culturally appropriate handling of pregnancy tissue, written information and bereavement / mental-health follow-up. Avoid blame and stigmatizing terminology.

## 12. Acute abnormal uterine bleeding

### 12.1 Stabilization and cause assessment

Priority	Action
Physiology first	Quantify ongoing bleeding; obtain serial observations, IV access, full blood count, pregnancy test, crossmatch and coagulation. Activate major-haemorrhage support for instability or continuing brisk loss.
Exclude pregnancy-related bleeding	A positive or uncertain pregnancy test moves the patient to the early-pregnancy pathway until ectopic pregnancy and pregnancy loss are addressed.
Identify contributors	Use PALM-COEIN: polyp, adenomyosis, leiomyoma, malignancy / hyperplasia; coagulopathy, ovulatory dysfunction, endometrial, iatrogenic and not otherwise classified. Review anticoagulants, hormones, devices and bleeding disorders.
Medical control	For stable patients, use the locally approved high-dose progestin, combined hormonal or tranexamic-acid regimen after contraindication review. Oestrogen-containing treatment is inappropriate in many patients with thrombotic, vascular, hepatic or migraine risks.
Procedural control	Persistent instability, refractory bleeding, structural lesion, retained tissue or inability to use medical therapy may require uterine tamponade, hysteroscopy, dilation and curettage / aspiration, uterine-artery embolization or surgery.
Transfusion / iron	Use restrictive, symptom- and physiology-guided transfusion when stable; correct severe iron deficiency and arrange follow-up. Do not rely on initial haemoglobin during acute loss.

### 12.2 Special AUB contexts

Context	Additional requirement
Adolescent	Assess haemodynamic stability, pregnancy, sexual safety and bleeding disorder. Medical management is usually first-line. Involve paediatrics / adolescent gynaecology and respect confidential care within legal limits.
Anticoagulated patient	Treat life-threatening haemorrhage and discuss reversal with haematology / relevant specialty; balance thrombosis risk. Do not stop



Context	Additional requirement
	essential anticoagulation without a documented plan.
Postmenopausal bleeding	Any bleeding requires urgent diagnostic follow-up because malignancy must be excluded. Stabilize acute loss; arrange gynaecology assessment, transvaginal ultrasound and endometrial sampling according to current local / specialist guidance.
Known fibroid / prolapsing fibroid	Treat haemorrhage and pain; examine for a prolapsing infected or necrotic mass; urgent gynaecology if heavy bleeding, sepsis, urinary obstruction or tissue is trapped at the cervix / vagina.
Possible coagulopathy	Ask about bleeding since menarche, postpartum / surgical bleeding, epistaxis, bruising and family history; involve haematology and avoid therapies that worsen bleeding.

### 13. Adnexal torsion

- Suspect torsion with sudden severe unilateral pain, recurrent colicky episodes, nausea / vomiting, adnexal tenderness or a known ovarian mass. Children, adolescents, pregnancy and fertility-treatment patients may present atypically.
- Call gynaecology early. Record the onset and any pain-free intervals. Keep nil by mouth, provide analgesia / antiemetics, establish IV access and prepare for laparoscopy or urgent transfer.
- Pelvic ultrasound with Doppler supports assessment but does not rule out torsion. Preserved arterial flow, intermittent symptoms, normal laboratory tests or temporary pain improvement must not delay surgery when suspicion remains high.
- Torsion is ultimately a surgical diagnosis. Detorsion with ovarian preservation is preferred when feasible; apparent discoloration alone does not reliably establish nonviability.
- Consider torsion of a normal adnexa in paediatric / adolescent patients and isolated tubal torsion, torsion of a paraovarian cyst or torsion during pregnancy.

**TORSION TIME RULE: The operational goal is urgent gynaecological decision and theatre / transfer readiness, not diagnostic perfection. Every avoidable delay when torsion is plausible requires review.**

### 14. Ruptured or haemorrhagic ovarian cyst and adnexal mass accident

Clinical pattern	Management
Stable, limited haemoperitoneum	Analgesia, pregnancy exclusion, full blood count, ultrasound, serial observations and reassessment. Discharge only when pain and physiology improve and follow-up is reliable.
Ongoing bleeding / instability	Resuscitate, crossmatch, urgent gynaecology and operative / interventional source control. Consider anticoagulation reversal and alternative vascular / ectopic causes.
Complex or suspicious mass	Do not label as a simple cyst without appropriate imaging. Arrange urgent gynaecology / oncology pathway according to age, menopausal status, morphology, ascites and tumour-risk features.
Postmenopausal acute pain	Consider torsion, rupture or haemorrhage as well as gastrointestinal / urinary / vascular causes. Use ultrasound and CT according to clinical suspicion and obtain urgent specialist review.
Endometrioma / fibroid degeneration	Treat pain and exclude torsion, haemorrhage, infection and pregnancy-related emergencies. Persistent severe symptoms or diagnostic uncertainty requires admission / specialist review.

### 15. Pelvic inflammatory disease, tubo-ovarian abscess, and pelvic sepsis

Assessment / state	Required response
Empiric PID threshold	Pelvic or lower abdominal pain with cervical motion, uterine or adnexal tenderness and no better explanation justifies empiric broad-spectrum treatment. Negative STI tests do not exclude upper-tract infection.
Outpatient candidate	Mild to moderate illness, pregnancy excluded, oral medication tolerated, no TOA, reliable follow-up and no surgical emergency. Use a locally approved regimen that covers gonorrhoea, chlamydia and anaerobes; reassess within 48–72 hours.
Admission indicators	Pregnancy, severe illness / high fever, vomiting, inability to tolerate oral therapy, TOA, immunocompromise, uncertain diagnosis / possible

Assessment / state	Required response
	surgical emergency, failed outpatient therapy or unreliable follow-up.
<b>Tubo-ovarian abscess</b>	Admit for IV antibiotics and gynaecology. Large, persistent or poorly responding abscess may need image-guided drainage or surgery. Rupture, peritonitis, shock or worsening organ dysfunction requires immediate source control.
<b>Septic shock</b>	Cultures when feasible, immediate broad-spectrum IV antibiotics, lactate / organ support, balanced fluids, vasopressors when indicated and urgent source control. Follow the sepsis protocol.
<b>IUD present</b>	Routine immediate removal is not always required. Coordinate with gynaecology / sexual health; consider removal if no clinical improvement after 48–72 hours or according to patient preference and local guidance.
<b>Partner / prevention care</b>	Arrange STI notification and treatment, abstinence until treatment completion and partner management, HIV / syphilis testing, contraception and sexual-health follow-up.

## 16. Vulval, vaginal, and cervical emergencies

Condition	Emergency-department management
<b>Bartholin abscess</b>	Provide analgesia and drainage by an approved method, usually Word catheter when trained. Add antibiotics for cellulitis, systemic illness, pregnancy, immunocompromise, MRSA risk or local indication. New Bartholin-region mass in patients aged 40 or older / postmenopausal requires biopsy or urgent specialist review.
<b>Vulval / vaginal haematoma</b>	Assess haemodynamic stability, expansion, urinary retention, anticoagulation and trauma / obstetric history. Apply pressure / ice when small and stable; urgent gynaecology, imaging and drainage / embolization for expanding or unstable haematoma.
<b>Foreign body</b>	Remove under direct visualization when safe; avoid blind instrumentation. Consider imaging, sedation / anaesthesia, safeguarding and specialist removal for sharp, embedded, high or long-retained objects.
<b>Cervical / vaginal haemorrhage</b>	Use speculum examination, direct pressure and specialist haemostatic measures. Do not blindly clamp. Consider malignancy, trauma, pregnancy tissue, anticoagulation and sexual assault.
<b>Acute vulval ulceration / necrosis</b>	Assess for infection, HSV, inflammatory disease, malignancy, drug reaction, Fournier gangrene and immune compromise. Necrosis, crepitus, severe pain out of proportion or systemic toxicity requires immediate surgery / sepsis response.
<b>Pelvic organ prolapse with incarceration / ulceration</b>	Reduce only when appropriate and trained; provide analgesia, bladder assessment and urgent gynaecology for ischaemia, urinary obstruction, bleeding or failed reduction.

## 17. Other time-critical gynaecological conditions

Condition	Key actions
<b>Ovarian hyperstimulation syndrome</b>	Consider after fertility treatment with enlarged ovaries, ascites, pain, vomiting, haemoconcentration, oliguria, dyspnoea or thrombosis. Avoid routine pelvic pressure / repeated examination, assess renal / respiratory status and thrombosis, involve fertility / gynaecology and admit moderate-severe disease.
<b>Obstructive uterovaginal anomaly / haematocolpos</b>	Adolescent with primary amenorrhoea, cyclical pain, urinary retention, mass or constipation. Avoid unplanned incision; provide analgesia, bladder care, ultrasound and specialist surgical referral.
<b>Degenerating or prolapsing fibroid</b>	Treat pain, bleeding and infection; urgent gynaecology for haemorrhage, sepsis, urinary obstruction, necrotic prolapsed tissue or uncertain diagnosis.
<b>Device complication</b>	Pregnancy with an IUD requires ectopic exclusion. Missing strings, perforation, migration, severe pain or infection requires pregnancy test,



Condition	Key actions
	imaging and specialist plan; do not perform blind removal.
<b>Gynaecological malignancy complication</b>	Major bleeding, obstruction, fistula, thrombosis, ascites, infection or severe pain requires stabilization, gynaecology / oncology contact and individualized goals-of-care planning.
<b>Non-gynaecological mimic</b>	Appendicitis, urinary tract disease, bowel obstruction, diverticulitis, vascular catastrophe, hernia, musculoskeletal and metabolic causes remain active differentials; broaden imaging / consultation when the course does not fit.

## 18. Medication, transfusion, and procedural safety

- Use weight, renal / hepatic function, pregnancy status, thrombosis risk, migraine / smoking history, allergy, current hormones and anticoagulants to verify treatment.
- High-dose hormonal therapy, methotrexate, concentrated oxytocics where used, tranexamic acid, anticoagulant reversal, opioids, procedural sedation and IV antibiotics require approved order sets, contraindication checks and monitoring.
- Methotrexate must never be given solely for an undesired or uncertain intrauterine pregnancy or on the basis of a single hCG result. Confirm specialist diagnosis, indications, contraindications and follow-up ownership.
- For major haemorrhage, use the local massive-transfusion protocol, active warming, calcium and coagulation monitoring, and early source control. Avoid excessive crystalloid.
- Intimate examination, transvaginal ultrasound, uterine aspiration, drainage and sedation require consent whenever capacity allows, chaperone, privacy, analgesia and documentation of findings and specimens.
- Where local anti-D policy differs from NICE 2026, the approved national / institutional policy governs. Document gestation, RhD status, indication, dose, consent and administration.

## 19. Monitoring and reassessment

Risk level	Minimum monitoring
<b>Unstable / major haemorrhage / sepsis</b>	Continuous ECG and oxygen saturation, BP every 3–5 minutes or invasive monitoring, frequent mental-status and perfusion review, urine output, bleeding measurement, blood gas / lactate, haemoglobin / coagulation and response to source-control treatment.
<b>Possible ectopic / internal bleeding</b>	Serial pulse, BP, pain, abdominal findings, shoulder / rectal symptoms, syncope, haemoglobin and ultrasound / hCG plan. Any deterioration triggers immediate operative review.
<b>Suspected torsion</b>	Frequent pain and abdominal reassessment while awaiting theatre / transfer; do not use analgesic response as an exclusion test.
<b>AUB under medical treatment</b>	Bleeding rate, pad counts / objective loss when feasible, vital signs, haemoglobin symptoms, medication adverse effects and need for procedural escalation.
<b>PID / TOA</b>	Temperature, pain, abdominal / pelvic findings, oral tolerance, sepsis markers and clinical response. Lack of improvement within 48–72 hours requires diagnostic and source-control reassessment.
<b>Observation patient</b>	Named clinician, explicit diagnostic uncertainty, repeat-examination schedule, pending-result plan, escalation thresholds and maximum observation duration.

## 20. Disposition, admission, and transfer

Disposition	Minimum criteria
<b>Immediate theatre / operative pathway</b>	Suspected ruptured ectopic, uncontrolled haemorrhage, adnexal torsion, ruptured TOA, septic retained tissue, uterine / visceral perforation, necrotizing infection or other source requiring emergency surgery.
<b>Critical care / high-dependency</b>	Major transfusion, vasopressors, respiratory failure, severe sepsis / shock, persistent metabolic derangement, ongoing haemorrhage or need for invasive monitoring.
<b>Urgent specialist transfer</b>	Required gynaecology, theatre, anaesthesia, blood bank, interventional radiology or ICU capability is unavailable. Stabilize without delaying definitive care; confirm acceptance, escort, blood / medication and deterioration plan.

Disposition	Minimum criteria
Gynaecology admission	Significant bleeding / anaemia, ectopic treatment, PUL with concerning course, severe pain, TOA / inpatient PID, complex mass, failed outpatient treatment, post-procedural complication or unreliable follow-up.
Observation	Only with stable physiology, controlled symptoms, no immediate surgical indication, clear timed reassessment and reliable access to imaging / specialist review.
Discharge	Normal and stable observations, pain / bleeding controlled, dangerous causes reasonably excluded or safely managed, pregnancy / hCG plan complete, patient able to understand return precautions, and named follow-up / result ownership documented.

## 21. Communication, dignity, pregnancy loss, and safeguarding

- Address the patient directly and privately. Use the patient's preferred name and reproductive / gender terminology while preserving clinically necessary information.
- Explain uncertainty honestly: "pregnancy of unknown location," "possible torsion" or "cause not yet established" is safer than false reassurance. Provide written instructions and a 24-hour contact route.
- Pregnancy loss and abortion complications require compassionate, non-judgemental care regardless of whether the pregnancy was intended or how treatment was obtained. Emergency care must not be delayed by legal or social questions.
- Offer an interpreter, support person, pain relief, menstrual products, privacy and culturally appropriate bereavement / spiritual support. Ask permission before discussing fertility or pregnancy plans.
- Activate safeguarding for sexual assault, reproductive coercion, trafficking, intimate-partner violence, child protection concerns, impaired capacity or unsafe discharge. Minimize repeated intimate examination and preserve forensic options.
- Provide contraception and STI information when appropriate, but do not make access to emergency treatment conditional on counselling or disclosure.

## 22. Documentation and handover

Required element	Document explicitly
Timeline	Onset, arrival, pregnancy test, recognition of instability, calls, imaging, medication, blood, procedure, theatre / transfer acceptance and response.
Pregnancy / reproductive context	LMP / gestation estimate, contraception, fertility treatment, prior ectopic / procedure, pregnancy test and hCG results, ultrasound location / viability and RhD / anti-D decision.
Bleeding / physiology	Cumulative visible loss, clots / tissue, serial pulse / BP / shock index, mental status, urine output, haemoglobin, coagulation and transfusion.
Examination	Abdominal and pelvic findings, consent, chaperone, limitations, tissue / foreign body, cervical os, tenderness / mass and safeguarding concerns.
Clinical reasoning	Working diagnosis, dangerous alternatives considered, why imaging / surgery / observation / discharge was chosen, and what remains unresolved.
Treatment	Drug name, dose, route, time, contraindication review, response, adverse effects, blood products and procedures.
Consultation / transfer	Names, times, advice, accepting clinician / facility, transport level, escort, monitoring and contingency plan.
Discharge / follow-up	Written return precautions, 24-hour access, hCG / ultrasound / pathology / culture ownership, medication instructions and patient understanding.

## 23. Quality standards and audit indicators

Suggested indicator	Target / review question
Pregnancy status documented	100% of clinically relevant reproductive-potential presentations, with reason documented when not tested.
Time to senior review for instability / suspected rupture	Immediate; every avoidable delay reviewed.

Suggested indicator	Target / review question
Time to gynaecology call for suspected torsion	At recognition, before completion of nonessential testing.
PUL follow-up ownership	100% have named service, repeat-test date, 24-hour access and written safety-netting.
Major AUB haemorrhage response	Timely IV access, crossmatch, haemorrhage activation and source-control decision.
PID outpatient reassessment	Documented 48–72-hour review plan and STI / partner pathway.
Intimate examination governance	Consent and chaperone documented; avoidable repeat examinations reviewed.
Pregnancy-loss experience	Information, analgesia, privacy and support documented; complaints and bereavement feedback reviewed.
Transfer performance	Acceptance, departure time, transport capability and adverse events audited.
Diagnostic return / harm events	Delayed ectopic, torsion-related organ loss, ruptured TOA, missed malignancy, unplanned return and unexpected transfusion / surgery reviewed through governance.

## 24. Minimum equipment, medication, and training readiness

Capability	Minimum readiness requirement
Resuscitation / haemorrhage	Adult resuscitation equipment, large-bore IV / IO access, rapid infusion / pressure devices, warming, emergency blood, massive-transfusion activation and point-of-care ultrasound.
Pelvic assessment	Pregnancy tests, specula of suitable sizes, light source, swabs, chaperone process, menstrual products, tissue containers, bladder scanner and urinary catheters.
Imaging	24-hour access or transfer pathway for transvaginal / transabdominal ultrasound with Doppler and emergency CT / MRI as indicated.
Medications	Analgesics, antiemetics, broad-spectrum PID / sepsis antibiotics, locally approved AUB hormonal regimens, tranexamic acid, blood-product adjuncts, anti-D where applicable and emergency reversal agents.
Procedures	Uterine aspiration / evacuation capability or transfer, Word catheter / abscess drainage equipment, procedural sedation, theatre / laparoscopy access and interventional-radiology pathway where available.
Training	Simulation for ruptured ectopic, major AUB, torsion transfer, septic miscarriage / abortion, TOA rupture and safeguarding / trauma-informed intimate examination.
Referral network	Named 24-hour gynaecology, early-pregnancy, ultrasound, theatre, blood bank, sexual-health, safeguarding, mental-health and tertiary-transfer contacts.

## 25. Selected evidence and guidance base

Source	Use in this protocol
NICE NG126. Ectopic pregnancy and miscarriage: diagnosis and initial management. Updated 17 June 2026.	Early-pregnancy referral, ultrasound and PUL principles, miscarriage / ectopic management and updated anti-D recommendations.
ACOG Practice Bulletin No. 193. Tubal Ectopic Pregnancy.	Diagnosis, expectant / methotrexate / surgical management principles and follow-up.
ACOG Practice Bulletin: Early Pregnancy Loss.	Diagnosis and expectant, medical and surgical management of miscarriage.
ACOG Committee Opinion No. 557. Management of Acute Abnormal Uterine Bleeding in Nonpregnant Reproductive-Aged Women.	Initial stabilization, PALM-COEIN assessment, medical and procedural bleeding control.
ACOG Committee Opinion No. 783. Adnexal Torsion in Adolescents.	Torsion as a surgical diagnosis, limitations of Doppler and adnexal preservation.
CDC. Sexually Transmitted Infections Treatment Guidelines: Pelvic Inflammatory Disease. Current online guidance.	Empiric PID threshold, outpatient / inpatient therapy, admission criteria and partner management.

Source	Use in this protocol
<b>ACR Appropriateness Criteria: Acute Pelvic Pain in the Reproductive Age Group, 2023 update.</b>	Ultrasound / Doppler as first-line imaging and CT / MRI selection by pregnancy status and suspected cause.
<b>ACR Appropriateness Criteria: Postmenopausal Acute Pelvic Pain.</b>	Imaging approach in postmenopausal acute pain.
<b>ACOG 2026 updated guidance on evaluation of postmenopausal bleeding.</b>	Urgent malignancy exclusion with transvaginal ultrasound and endometrial tissue assessment for most patients.
<b>WHO. Abortion care guideline, 2nd edition, 2025; Clinical practice handbook for quality abortion care.</b>	Non-stigmatizing emergency management of haemorrhage, infection, retained tissue and injury after abortion.
<b>RCOG Green-top Guidelines on ovarian cysts and emergency gynaecology training standards.</b>	Adnexal mass risk, postmenopausal cyst accidents and acute gynaecology service expectations.

### Evidence governance note

- Local approval must reconcile differences between national anti-D policies, abortion law and service scope, antibiotic resistance, blood-product availability and inter-island transfer capability.
- Any medication dose or procedural pathway should be implemented through a locally controlled order set with pharmacy, gynaecology, anaesthesia and nursing sign-off.
- Where a guideline is older but remains the active professional-society standard, the local review group should document whether newer evidence or national policy changes practice.
- Patient information, consent language and discharge instructions should be reviewed with service users, bereavement teams, sexual-health staff and safeguarding leads.
- The protocol should be rechecked after publication of materially relevant NICE, WHO, ACOG, RCOG, CDC or national guidance and after any serious incident.

## Annex A. One-page acute gynaecological emergency workflow

Step	Action
1. Recognize	Red flags: collapse / shock, major bleeding, positive pregnancy test with pain, peritonism, sudden unilateral pain / vomiting, fever / sepsis, recent uterine procedure, expanding vulval haematoma.
2. Stabilize	ABCDE, monitors, glucose, analgesia, two IVs, full blood count / crossmatch / coagulation / chemistry / lactate, pregnancy test / hCG, warmed blood products when needed.
3. Activate	Senior ED + gynaecology; add anaesthesia / ICU, theatre, blood bank, surgery, radiology, safeguarding and transfer according to likely emergency.
4. Identify branch	Pregnancy-related / PUL; acute uterine bleeding; torsion / adnexal accident; PID / TOA / sepsis; post-procedural injury; vulval / vaginal emergency; non-gynaecological mimic.
5. Image safely	TVUS + transabdominal ultrasound / Doppler for suspected gynaecological cause. CT for dangerous alternative, perforation, abscess or unclear serious illness. Do not delay surgery for unstable rupture or high-suspicion torsion.
6. Treat now	Haemorrhage control / blood; sepsis antibiotics + source control; torsion theatre / transfer; ectopic plan; AUB medical / procedural control; analgesia and antiemetics.
7. Reassess	Trend vital signs, bleeding, pain, abdomen, haemoglobin / lactate, response and diagnostic uncertainty. Escalate any deterioration.
8. Disposition	Theatre / ICU / admission / transfer, or discharge only with stable physiology, controlled symptoms, named follow-up, outstanding-result ownership and written 24-hour return precautions.

## Annex B. Initial assessment record

Required field	Entry
Arrival / triage / senior review time	_____
Presenting complaint / onset / severity	_____
LMP / cycle / pregnancy possibility / test	_____
Recent pregnancy / abortion / procedure / fertility treatment	_____
Bleeding amount / pads / clots / tissue	_____
Pain site / sudden / intermittent / vomiting	_____
Fever / discharge / STI / safeguarding concerns	_____
Medications / anticoagulants / hormones / allergies	_____
Serial pulse / BP / shock index / temperature / GCS	_____
Abdominal / pelvic examination / chaperone	_____
FBC / group / hCG / chemistry / coagulation / lactate	_____
Ultrasound / CT / critical result	_____
Working diagnosis / uncertainty / differential	_____
Consultant / gynaecology / theatre / transfer calls	_____
Treatment / response / disposition	_____

## Annex C. Early-pregnancy pain / bleeding and PUL checklist

Check	Complete / finding
Haemodynamic stability / peritonism / shoulder-tip pain / syncope	_____
Pregnancy test and quantitative hCG	_____
LMP / gestation / prior ectopic / IUD / fertility treatment	_____
FBC / group / RhD / crossmatch if indicated	_____
TVUS performed by qualified service / limitations explained	_____
IUP, ectopic, PUL, uncertain viability or miscarriage category	_____
Free fluid / adnexal findings / heterotopic assessment	_____
Immediate surgery / methotrexate / expectant / miscarriage plan	_____
Anti-D decision under local policy	_____
Repeat hCG / ultrasound date and responsible service	_____
24-hour contact and written ectopic rupture precautions	_____
Pregnancy-loss / fertility / mental-health support offered	_____

## Annex D. Torsion and acute adnexal emergency checklist

Check	Complete / finding
Sudden / intermittent unilateral pain and onset time	_____
Nausea / vomiting / prior episodes / known mass	_____
Pregnancy / fertility treatment / paediatric or adolescent context	_____
Gynaecology call time and decision maker	_____
Nil by mouth / IV / analgesia / antiemetic	_____
Ultrasound + Doppler result and limitations	_____
Normal Doppler not used to exclude torsion	_____
Theatre / laparoscopy or transfer activation time	_____
Alternative ectopic / appendicitis / renal / bowel cause considered	_____
Delay or cancellation reason documented	_____

## Annex E. Acute abnormal uterine bleeding checklist

Check	Complete / finding
Pregnancy excluded or pregnancy pathway activated	_____
Bleeding rate / clots / cumulative loss / shock index	_____
FBC / crossmatch / coagulation / ferritin when appropriate	_____
Anticoagulant / bleeding disorder / PALM-COEIN assessment	_____
Medical regimen / contraindication review / administration time	_____
Blood products / iron / reversal plan	_____
Gynaecology review / procedural source-control threshold	_____
Postmenopausal malignancy-exclusion pathway	_____
Bleeding controlled and serial observations stable	_____
Follow-up and return precautions documented	_____



## Annex F. PID / tubo-ovarian abscess checklist

Check	Complete / finding
Pregnancy / ectopic and surgical causes considered	_____
Cervical motion / uterine / adnexal tenderness	_____
Fever / sepsis / vomiting / oral tolerance	_____
NAAT / vaginal tests / HIV / syphilis / cultures as indicated	_____
Ultrasound / CT and TOA size / rupture concern	_____
Antibiotic regimen / first-dose time	_____
Admission indication or outpatient eligibility documented	_____
IUD plan and patient preference	_____
Partner notification / abstinence / sexual-health referral	_____
48–72-hour reassessment or inpatient source-control plan	_____

## Annex G. Discharge safety-net

Return immediately / call emergency services for	Examples
Bleeding danger	Rapid pad saturation, large clots, bleeding increasing, fainting, racing heart, breathlessness, severe weakness or pallor.
Ectopic / internal bleeding danger	New or worsening one-sided pain, shoulder-tip pain, rectal pressure, collapse, dizziness or abdominal swelling.
Torsion / surgical danger	Sudden severe or recurrent pain, persistent vomiting, inability to walk / function or pain not controlled by prescribed medication.
Infection danger	Fever, rigors, offensive discharge, worsening pelvic pain, vomiting, confusion, reduced urine or feeling rapidly more unwell.
Post-procedural danger	Severe pain, heavy bleeding, fainting, fever, abdominal distension, inability to pass urine or concern that pregnancy symptoms persist.
Follow-up failure	Unable to obtain the scheduled hCG / ultrasound / clinic review, positive pregnancy test when told to repeat it, or no contact about an outstanding critical result.

## Annex H. Local configuration checklist

Local element	Complete before approval
24-hour gynaecology / early-pregnancy contact and response time	Name / number: _____
Theatre / anaesthesia / ICU activation	Policy / number: _____
Ultrasound service and out-of-hours transfer	Service: _____
Major-haemorrhage / emergency blood pathway	Policy: _____
PUL serial hCG and ultrasound ownership	Service: _____
Approved ectopic / methotrexate pathway	Policy: _____
Approved AUB medication regimens and contraindications	Order set: _____
PID / TOA antibiotic regimens and drainage pathway	Order set: _____
Anti-D policy following June 2026 evidence update	Policy: _____
Pregnancy-loss tissue / pathology / bereavement process	Policy: _____
Sexual assault / safeguarding / adolescent confidentiality pathway	Policy: _____
Word catheter / vulval abscess capability	Location / trained staff: _____
Tertiary gynaecology / interventional radiology / oncology transfer	Facility / contact: _____
Audit lead and review date	Name / date: _____