TE WAIORA Nelson Marlborough Health

DHB Office
Braemar Campus

Private Bag 18
Nelson, New Zealand

23 November 2021

[redacted]

Response to a request for official information

[redacted]

Thank you for your request for official information received 21 September 2021 by Nelson Marlborough Health (NMH), followed by the necessary extension of time 19 October 2021 and notice of decision 17 November 2021, where you seek the following information.

***NOTE:** COVID-19 impacted on our delivery of non-urgent services, particularly during 2020.

1. ***Of all the patients with endometriosis seen by a specialist in the last 12 months, what was the average wait time for that appointment?***

Response: 97 days.

2. ***Of all the patients with endometriosis seen by a specialist in the last 12 months, what was the longest and shortest wait time for that appointment?***

Response:

TABLE 1

New OP visit waiting time	
Longest	182 days
Shortest	9 days

3. ***In the last 12 months how many patients have seen a specialist at the DHB for endometriosis?***

NMH response: 14 patients.

4. ***In the last 12 months, how many patients have been transferred to another hospital to treat endometriosis?***

NMH response:
There is no record of patient transfers to another DHB to treat endometriosis in the last 12 months.

5. ***How many specialists does the DHB have available to diagnose and treat severe endometriosis?***

NMH response:
We currently have 7 Obstetricians/Gynaecologists and another due to commence employment.

6. ***Of the patients who had advanced laparoscopic surgery to treat endometriosis in the last 12 months, what was the average wait time to get that operation?***

NMH response: 88 days for patients with endometriosis as the primary diagnosis, noting there is no mention of *advanced* in the procedure description.

7. ***Of the patients who had advanced laparoscopic surgery to treat endometriosis in the last 12 months, what was the longest and shortest wait time to get that operation?***

NMH response: Please see Table 2 for patients with endometriosis as the primary diagnosis, noting there is no mention of *advanced* in the procedure description.

TABLE 2

Laparoscopic surgery waiting time	
Longest	306 days
Shortest	11 days

8. ***A copy of the DHBs clinical pathway to treat endometriosis.***

NMH response: Please see the enclosed *Nelson Marlborough Community HealthPathway – Endometriosis.*

9. ***Of the patients who saw a specialist with serious back pain, in the last 12 months, what was the average wait time for that appointment?***

NMH response: 4 days for one of the following referral reasons- *Acute back pain with sciatica*, *Thoracic back pain*, or *Low back pain*.

10. ***Of the patients who saw a specialist with serious back pain, in the last 12 months, what was the longest and shortest wait time for that appointment?***

NMH response:

TABLE 3

New OP visit waiting time	
Longest	10 days
Shortest	1 day

11. ***Of the patients who had orthopaedic surgery to treat back pain, in the last 12 months, what was the average wait time for that appointment?***

NMH response: There were no surgical admissions for '*back pain*'.

12. ***Of the patients who had orthopaedic surgery to treat back pain, in the last 12 months, what was the longest and shortest wait time for that operation?***

NMH response: Please refer to Q11 above.

This decision has been provided under the Official Information Act 1982. You have the right to seek an investigation by the Ombudsman of this decision. Information about how to make a complaint is available at www.ombudsman.parliament.nz or free phone 0800 802 602. If you have any questions about this decision please feel free to email our OIA Coordinator OIArequest@nmdhb.govt.nz

I trust this information meets your requirements. NMH, like other agencies across the state sector, supports the open disclosure of information to assist the public's understanding of how we are delivering publicly-funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released. If you feel that there are good reasons why your response should not be made publicly available, we will be happy to consider.

Yours sincerely

Lexie O'Shea
Chief Executive

Encl: *Nelson Marlborough Community HealthPathway – Endometriosis*

Endometriosis

See also Pelvic Pain (Chronic)

Background

About endometriosis

Assessment

1. Endometriosis is one of several causes of pelvic pain. Take a history to help with differential diagnosis.
2. Recording symptoms in a menstrual diary may be helpful. Menstrual diary apps are available for smart phones.
3. Specifically enquire about:
    - pelvic pain, which may or may not be cyclical
    - deep dyspareunia
    - dyschezia or other bowel symptoms
    - pain on urination, or urinary frequency
    - pain during exercise
    - lethargy
    - history of sub fertility.
4. Examine abdomen and pelvis, including speculum and bimanual examination:
    - Pelvic tenderness
    - A fixed retroverted uterus
    - Enlarged ovaries
    - Palpable nodules on the utero-sacral ligaments or in the pouch of Douglas
    - Visible endometriotic lesions in the vagina or on the cervix

      Note: Pelvic examination should not be performed if patient is not yet sexually active.
5. Investigations are usually normal, but may be useful in the differential diagnosis. Consider STI swabs, urinalysis, CBC, and CRP.
6. Ultrasound is not indicated unless there is a mass palpable on pelvic examination.
7. Laparoscopy is the gold standard for diagnosis of endometriosis, but in most instances a trial of therapy is attempted first as below.

Management

If endometriosis is suspected, provide patient information and manage as below:

1. Lifestyle modification:
    - Smoking cessation
    - Limit fatty food, caffeine and alcohol
    - Reduce overweight
    - Regular daily exercise
    - Manage stress
2. Symptomatic treatment:
    - Individualise to the patient
    - Start with simple analgesia
    - NSAIDs in usual therapeutic doses started as soon as the woman knows her period is coming, to prevent prostaglandin release.
    - If bleeding is heavy, consider tranexamic acid.
3. Hormonal manipulation:

- This may be effective in all cases of cyclical pelvic pain whether due to endometriosis or not.
- The latest NZ guidelines suggest progestin-dominant therapy is most likely to be successful, although treatment choice must be balanced with contraceptive requirements and adverse effects.
- First choice is a non-contraceptive progestogen.
- If contraception is required, consider a contraceptive progestogen or a combined oral contraceptive (COCP).

4. Treatments may be combined if required e.g., NSAID + COCP, COCP + supplementary progestin.
5. Consider referral to gynaecology outpatients if hormonal treatment fails after six months trial, or is inappropriate because of wish for pregnancy.
6. Goserelin (Zoladex), an injectable GnRH agonist may be used under specialist guidance.

Request

Refer to gynaecology outpatients if:

- dyschezia or deep dyspareunia
- failure to respond to 6 months of medical management
- previously diagnosed endometriosis and return of symptoms not responding to appropriate medical management
- worsening symptoms and hormonal management not appropriate because of wish for pregnancy.

Your patient may also wish to consider private referral to a gynaecologist.

Information

Clinical Resources
Patient Information

SOURCES

References

1. Read CM. New regimens with combined oral contraceptive pills – moving away from traditional 21/7 cycles. Eur J Contracept Reprod Health Care. 2010;15 Suppl 2:S32-S41. [Abstract]

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