OBSTETRICS AND GYNAECOLOGY
CLINICAL PRACTICE GUIDELINE

Pain Management – Gynaecology [NEW]

Scope (Staff):	WNHS Obstetrics and Gynaecology Directorate staff
Scope (Area):	Obstetrics and Gynaecology Directorate clinical areas at KEMH, OPH and home visiting (e.g. Visiting Midwifery Services, Community Midwifery Program and Midwifery Group Practice)

This document should be read in conjunction with this Disclaimer

Contents

Aim

To deliver safe, consistent and holistic pain management that improves patient outcomes and minimises risk.

Background

Gynaecology pain, while a common presentation, is often complex. Patients' experiences of pain can affect quality of life, mental health and daily functioning.Pain is multifactorial and requires a multidisciplinary approach (RANZCOG, 2021).

Acute Flares of Chronic Pelvic Pain Management

For guidance on managing acute flares of chronic pelvic pain, please refer to WNHS clinical guideline – Pain: acute on chronic pelvic pain managment

Non-Pharmacological Management

Offering non-pharmacological pain management strategies can provide several benefits, including:

- Reduced pain perception
- Improved function and mobility
- Decreased anxiety
- Increased patient control over pain

Examples of non-pharmacological pain management strategies that may be used during a hospital presentation include:

- Heat or cold application
- Transcutaneous Electrical Nerve Stimulation (TENS) machines
- Music, distraction, or mindfulness techniques
- Aromatherapy

Cold and Heat Therapy – Local Application

- **Refer to** SCGH / OPH Nursing Practice Guideline No. 53 – Heat Cold Therapy (SCGOPHCG)

Consider cold therapy to reduce swelling or pain associated with soft tissue or musculoskeletal injury / vulva surgery where appropriate.

Consider heat therapy to assist with pain from muscle spasm.

Special note: When applying heat therapy:

- Ensure the heat pack is enclosed in a towel or protective cover.
- Do not apply heat packs directly to the skin to prevent burns.
- Heat packs must not be used in conjunction with neuraxial analgesia (e.g., epidural). Impaired sensation caused by an epidural increases the risk of unrecognised burns.
- If the epidural appears ineffective, contact the anaesthetist to review the patient.

Transcutaneous Electrical Nerve Stimulation (TENS)

Transcutaneous Electrical Nerve Stimulation (TENS) is a non-invasive method of pain relief that uses a battery-operated device to deliver low-voltage electrical currents through the skin.

This pain management intervention may be initiated and implemented by nursing staff where no contraindications are identified. If a contraindication is present, medical staff approval is required prior to commencementTENS machines are available on Ward 6 and in the Emergency Centre for inpatient use.

When Commencing a TENS Machine for the First Time

1. Obtain patient consent.
2. Check for contraindications, including:
    - Epilepsy or seizure history
    - Electronic implants (e.g. pacemaker, defibrillator)
    - Implanted pulse generator
    - Deep vein thrombosis (DVT)
    - Bleeding disorders
    - Infection (e.g. tuberculosis, osteomyelitis)
    - Impaired circulation
    - Impaired sensation

- Pregnancy < 36 weeks
- Cancer
- Recently radiated tissues
- Recent fracture or sutures
- Compromised skin integrity (e.g. broken skin, lesions, moles)

Seek medical advice before use if contraindications above are present or:

- The patient has vaginal bleeding, or
- Investigations for an acute pain condition are ongoing.

Do NOT Use TENS

- Around the chest (intercostal or cardiac region)
- On the front of the neck or carotid sinus region
- In water (do not use during baths or showers)
- Over recently radiated tissues

Patient Education and Application

Provide the patient with the information leaflet: “The Use of TENS for Period Pain/Endometriosis.”

When applying TENS:

1. Place electrodes directly onto clean skin over the area of pain.
2. Instruct the patient to gradually increase the intensity until they feel a strong but comfortable pins-and-needles sensation.
3. Encourage normal activity and mobility while using the TENS machine.

Electrodes may be reused by the same patient multiple times.

TENS Settings and Modes

Teach the patient how to apply the TENS electrodes and commence the device using the recommended settings.

Two common stimulation modes may be used depending on the desired effect:

Mode	Theory / Mechanism	Recommended Settings	Effect
Pain Gate Theory	Suggests that “gates” in the spinal cord regulate the transmission of pain signals to the brain. Non-painful stimulation from TENS can close these gates, reducing transmission of painful signals and therefore reducing the perception of pain.	80–150 Hz 50–80 µs	Immediate onset Shorter acting pain relief
Acupuncture / Opioid Theory	Electrical stimulation activates nerve fibres that override painful signals. This stimulation promotes the release of endorphins (natural opioids) which help block pain signals reaching the brain.	1–4 Hz (or 0–10 Hz) 200 µs	Delayed onset Longer-lasting pain relief

Patient Education

- Demonstrate correct placement of electrodes over the area of pain.
- Teach the patient to gradually increase the intensity until a strong but comfortable tingling (pins and needles) sensation is felt.
- Encourage the patient to adjust intensity as needed for comfort and effectiveness.

Useful resources

Consumer information about TENS therapy is also available from the Australian Government via Healthdirect Australia: TENS (Transcutaneous Electrical Nerve Stimulation) – consumer information (external website)

Yoga Meditation and Acupressure

Evidence supports the use of yoga meditation and acupressure for management of pelvic pain.

For patient resources refer to Resources — Pelvic Pain Foundation of Australia

Pharmacological Management

Opioid Analgesic Stewardship in Acute Pain

Consider non-pharmacological analgesia, paracetamol, non-steriodal anti-inflammatory or other opioid-sparing strategies prior to commencement of opioid analgesia.

Careful assessment of opioid requirements prior to prescription with the aim to use at the lowest dose for the shortest duration to minimuse harm.

All opioid prescribing should align with the Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard (2022), developed by the Australian Commission on Safety and Quality in Health Care.

This standard promotes the appropriate and safe use of opioid analgesics, with effective monitoring and surveillance in healthcare settings.

Practice Points

- Prior to administering opioid analgesics, all patients should have a documented assessment of pain and function.
- In opioid-naïve patients, avoid prescribing opioids together with other central nervous system (CNS) depressants.
    - If co-prescribing is required, the clinical rationale should be documented.
- Paracetamol and a non-steroidal anti-inflammatory drug (NSAID) should be prescribed for patients receiving opioids unless contraindicated.
- Laxatives should be co-prescribed with opioid analgesics to reduce the risk of opioid-induced constipation.
- Discharge quantities of immediate-release opioids should be based on the amount used in the 24 hours prior to discharge.
- Routine prescribing of modified-release opioids should be avoided.
    - If used, the intended duration of therapy must be documented.
- Effectiveness of analgesia should be assessed and documented at least daily.
- Prescribing clinicians should discuss opioid therapy with patients and their caregivers, including:
    - Expected duration of treatment

    - Potential adverse effects
    - Interactions with existing medicines
- Monitoring the patient's understanding of acute pain treatment is important and may be supported through:
    - Pharmacist counselling
    - Acute Pain Service review, where available.

Further Information

Refer to:

Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard (2022) – Australian Commission on Safety and Quality in Health Care

Short Gynaecological Procedures

Underestimation of pain during gynaecology procedures has been reported.

Recommendations include:

- Discussing pain management options, utilising shared decision making and having culturally competent counselling.
- Anticipatory guidance and education prior to procedure has been shown to reduce anxiety and procedural pain.
- Individualising patient care and pain management with consideration of patient specific factors such as trauma history, baseline anxiety, age and experience with pelvic examinations should be attended prior to procedures.

Methoxyflurane

Methoxyflurane is an inhaled analgesic agent that provides effective pain relief for conscious, stable patients.

Indications

- Planned short procedures, e.g. gynaecology
- Early trimester delivery on Ward 6, in conjunction with the analgesia plan on MR810.07 – Medication Administered for Pregnancy Loss

Analgesic Duration

- Continuous use: up to 30 minutes
- Intermittent use: up to 1 hour

Common Side Effects

- Drowsiness
- Nausea or vomiting
- Hypotension (low blood pressure)
- Cough or asthma symptoms
- Unpleasant smell

Rare but Serious Risks

- Hepatic toxicity
- Malignant hyperthermia

Contraindications

Do not use Methoxyflurane in patients with:

- Allergy to Methoxyflurane
- Personal or family history of malignant hyperthermia
- Heart disease
- Liver disease – including underlying hepatic conditions or with risks for hepatic dysfunction
- Kidney disease or impaired kidney function
- Breathing difficulties
- Head injury

Discharge Advice

Patients receiving Methoxyflurane should:

- Be accompanied home by a responsible adult
- Not drive, operate machinery, or sign legal documents for 24 hours following administration

Administration and Monitoring

- Refer to Pharmacy Guidelines – Methoxyflurane for use and monitoring requirements during administration

Epidural and Post-Operative Pain

Refer to WNHS Clinical Guidelines: Anaesthesia and Pain Medicine (available via HealthPoint for WA Health employees) for management of:

- Neuraxial analgesia (epidural and intrathecal)
- Patient-controlled intravenous analgesia (PCIA): Postoperative use
- PCIA: Remifentanil and other PCIA in labour
- Rectus sheath catheter analgesia

Specific Gynaecology Conditions and Management

Condition	Pain Characteristics	First-Line / Non-Pharmacological Management	Escalation / Additional Management
Endometriosis	Pain is common and often complex	Short trial of NSAID ± paracetamol (unless contraindicated)	Refer to Acute on Chronic Pelvic Pain Guideline for acute flares or escalation The Australian Living Evidence Guideline: Endometriosis;Australian Living Evidence Guideline: Endometriosis
Vulvodynia	Vulvar pain ≥ 3 months	Follow chronic pain management principles, holistic care, avoid opioid escalation	Individualised chronic pain strategies; Refer to specialised clinics if needed Refer to: Guidelines for the management of vulvodynia - Mandal - 2010 - British Journal of Dermatology - Wiley Online Library Vulvodynia treatment guidelines - Melbourne Sexual Health Centre (MSHC)

Condition	Pain Characteristics	First-Line / Non-Pharmacological Management	Escalation / Additional Management
Pelvic Mesh Complications	Persistent pain after previous pelvic mesh surgery	Non-surgical therapies first line	Surgical removal of mesh may be offered on a case-by-case basis; manage expectations; multidisciplinary approach Pelvic mesh King Edward Memorial Hospital - Pelvic Mesh Complication Clinic

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North Metropolitan Health Service (2022) The Use of TENS for Period Pain/Endometriosis. Patient Brochure.

Related external policies, legislation and standards

Health Practitioner Regulation National Law (WA) Act 2010

Opioid Analgesic Stewardship in Acute Pain Clinical Care Standard 2022

NMHS Policy: Work Health and Safety

Related WNHS policies, guidelines and procedures

Anaesthetics: Neuraxial Analgesia (epidural and intrathecal) (access via HealthPoint)

Pharmacy: A-Z Adult (Obstetrics and Gynaecology) Medication Protocols: Morphine, Pethidine

Women's Health: Physiotherapy: Physiotherapy Use of Dry Needling and Western Acupuncture

Useful resources and related forms

Australian Living Evidence Guideline: Endometriosis

Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine (2020) Acute Pain Management

King Edward Memorial Hospital - Pelvic Mesh Complication Clinic

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Nursing and Midwifery Board (2022) Code of conduct

Pelvic Pain Foundation Pelvic Pain Foundation | Enhance Knowledge, Support Patients

WA Health Department: Pelvic mesh

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Version history

Version number	Date	Summary
1	June 2026	First version – this guideline was separated from Clinical Practice Guideline *Pain management (including labour non-pharmacological)* and was developed as a standalone document for Gynaecology

This document can be made available in alternative formats on request for a person with a disability.

Within the Department of Health WA, the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. No disrespect is intended to our Torres Strait Islander colleagues and community.

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