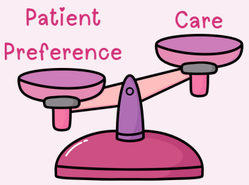
A small hospital manages a large pelvic mass in a socially complex women with diagnostic uncertainty in the Kimberley

Eloise Delaney[1] and Dr Elizabeth Gannon[1]

1. The Rural Clinical School of Western Australia

Introduction

Treating non-Medicare patients in rural settings requires careful deliberation, particulalry when they have complex social backgrounds and trauma associated with accessing healthcare.



Balancing patient preference with safe, high quality care is challenging. Minimising unnecessary procedures, to keep treatment costs low is therefore a top priority.

Additionally, the rural scope of practice can be limited compared with tertiary centres, and management options become limited when patients have experienced healthcare trauma and are unwilling to travel to larger centres for care.

Aim

To highlight that treating complex patients is challenging but possible, in rural settings where treatment options and support are limited.

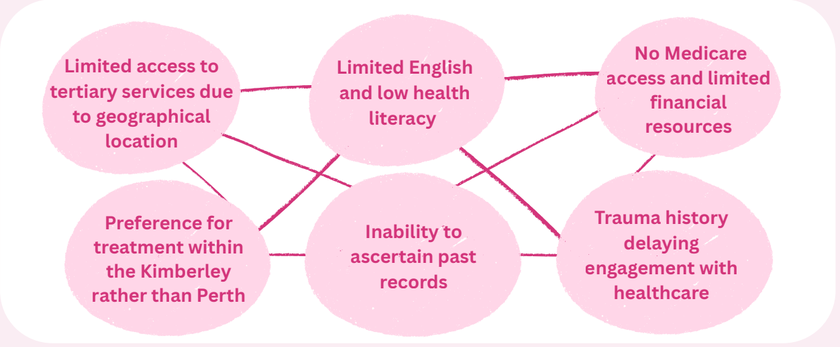
Case

A 42-year-old woman from Timor-Leste presented with a 2-year history of severe dysmenorrhea on a background of a traumatic cystectomy with unknown pathology in East-Timor years prior. Healthcare-related mistrust and previous sexual assaults delayed engagement with gynaecological care until she was in debilitating pain and was unable to work and send money back to her family. She presented to ED with peritonitis and concerns of evolving abdominal sepsis. Due to past healthcare trauma she refused to travel to a metropolitan site for tertiary level care.

Extensive multidisciplinary discussion was undertaken to balance the patient's preference for surgery in Broome with the department's concerns on case selection.

The medical and social aspects combined with private billing of a non-Medicare patient created discomfort in offering any procedure that did not achieve definitive treatment.

The complex interplay of multiple patient factors

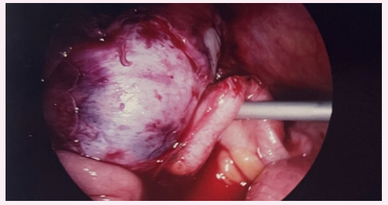


Results

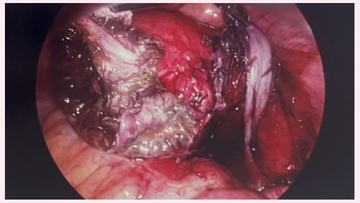
A decision to operate in the Kimberley was reached based on limited disease progression and investigations supporting full resolution of peritonitis.

An elevated CA-125 of 470 and complex 12.5cm cyst on imaging raised concerns for ovarian malignancy. Laparoscopy confirmed DIE and endometrioma with features in keeping with resolved peritonitis. Placement of a MIRENA IUD ensured affordable ongoing medical suppression of endometriosis.

The patient was successfully manged in a rural hospital and is now pain free and back working. Empasis was placed on patient education regarding the chronic and benign nature of endometriosis. The patient was disappointed that past surgeons had not explained her diagnosis to her.



A) Right adnexal endometrioma



B) Endometrioma post drainage

Conclusion

Optimal management was achieved by the Kimberley gynaecology team by careful and equal consideration of the patient's medical and psychosocial health. This case demonstrates that trauma-informed, patient-centred decision-making enabled complex surgical care to be delivered safely in a rural setting.