Advanced Training in Sexual Health Medicine

About this logbook

The logbook should demonstrate adequate exposure to clinical cases to be submitted at the end of Advanced Training in Sexual Health Medicine.

A logbook of cases should be kept by each trainee during the Sexual Health Medicine Advanced Training program. The purpose of the logbook is to:

- HIV Medicine and/or Reproductive cases seen during the program contributing to the achievement of specific curriculum learning goals.
- provide detail of the specific patient management and outcomes for each case
- reflect on how each case has contributed to learning and development
- provide a platform for discussion with supervisors.

Requirement

Over the course of training, trainees are required to complete:

• 1 x HIV medicine logbook
• 1 x Reproductive Health logbook
• 1 x Logbook for any 6-month elective undertaken (recommended)

Guidance for trainees when completing and submitting their logbook:

- 50 cases per logbook.
- For the HIV logbook, complex PEP/ PrEP cases can be included, however should not exceed 5 out of the total 50 cases.
- Cases should demonstrate patient demographic diversity, and broad clinical heterogeneity and complexity.
- The logbook should not include notes directly copied and pasted from a patient file, rather it should be a description of the case and outcomes, including investigation and management.
- Most cases should include learning or personal reflections, trainees should highlight appropriate contemporary guidelines, literature or evidence which assisted in understanding, learning and/ or patient management. These should be reference in an academic referencing style (e.g. AMA/ Harvard).

How to complete this logbook

Trainee - complete logbook

1. Download and save a local copy of this template. One logbook per requirement should be maintained over the course of training.
2. Review the required case types and number of case types required.
3. Plan how you will meet these requirements.
4. Enter the case information into the template.

Trainee - submit the logbook via TMP

- Submit your logbook for review via the TMP at the end of Advanced Training.

Outcome / TMP training record

- Submit your logbook in TMP at the end of your final phase of training.
- The Training Program Committee in Sexual Health Medicine review logbook submissions to confirm the requirement is completed.
- Once you have fulfilled an individual training requirement, it will be updated as complete in TMP.

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Training information

Trainee name Patricia Jackson

Training start date	Foundation year 2023
Training end date	Transition to Fellowship 2026
Submission date	09.03.2026
Supervisor(s)	Dr. Evelyn Reed
Accredited training site	Metropolitan Hospital 1, NSW

Resources

Sexual health medicine curriculum standards
• Learning goal links:
  ○ Learning goal 10: Investigations and procedures (EPA)
  ○ Learning goal 14: HIV (Knowledge)
  ○ Learning goal 17: Reproductive health (knowledge)

Sexual health medicine learning, teaching and assessment programs
TMP home page
TMP instructions – logbooks

This is a sample logbook to demonstrate the level of detail required. All Doctor and patient information have been de-identified. This logbook is an example of the required types of information trainees should provide in their logbook and does not contain the required number of cases as per the learning, teaching and assessment programs.

Record of Cases					
	Date	**Age of Patient**	**Diagnosis or Condition**	**Management considerations, and patient outcomes**	**Reflections on the case**
1.	21/1	26	Troublesome bleeding with the contraceptive implant	**Clinical details** • 26F heterosexual with persistent troublesome bleeding after the contraceptive implant was inserted in Sept 2020 (~4/12 ago). • BG intermittent small amounts of PV bleeding requiring a liner/light pad 3-4 weeks in a month. Prior to this, her usual menstrual cycle was regular with dysmenorrhoea and menorrhagia. She is keen to have reliable long-acting reversible contraception (LARC). **Management** • Detailed history re abnormal bleeding pattern to exclude suspicious causes. • Trial mefenamic acid 500mg PO TDS for 3-5 days (As per eTG) at commencement of bleeding. • If unsuccessful, trial Levlen ED COCP continuously for 3 months or with inactive pills. • Clarify that client has no UK MEC criteria for COCP (e.g. Migraine with aura, personal history of breast cancer/DVT/PE) prior to prescribing COCP • For review in 3-6/12 to assess if troublesome bleeding has improved • If unsuccessful, can consider removal of Implanon after discussion around contraceptive options that are appropriate or acceptable to her.	• There are many causes of abnormal PV bleeding but in this client, the likelihood is she is experiencing break through bleeding / troublesome bleeding due to the progesterone only contraceptive implant. • Important to assess history re troublesome bleeding, conduct investigations as required and offer viable options as per guidelines for management to the client (Including NSAID, tranexamic acid, additional COCP/OCP, and contraceptive implant removal) • As the client also reports heavy painful periods, she may be benefit from the Mirena IUD. The Mirena is a LARC LNG-IUD, used in the management of heavy menstrual bleeding (HMB). The IUD hormonal effect reduces the endometrial lining of the uterus. However, the insertion of a Mirena IUD is associated with further cost. Pain/discomfort during awake IUD insertion can occur. Both factors are barriers for clients.
2.	18/3	41	Pregnant 9/40 gestational age with positive syphilis results	**Clinical details** • 41F NESB G3P1T1 Gestation 9/40 G3P1T1 referred by GP with positive syphilis serology testing. Syphilis CMIA Positive TPPA Positive. RPR non-reactive. Same result when repeated in 2/52. Reports in monogamous relationship with 1 RMP for 5 years. • BG No available syphilis test result within the last 24 months. Reported previous diagnosis of syphilis in China about 10	• Congenital syphilis is a preventable condition. Syphilis in pregnancy needs to be treated at least 4 weeks before delivery. In LL syphilis in pregnancy, the risk of MTC transmission in <10%. Additionally, with the possible infection being >7 years ago, the risk of MTC transmission is further reduced. Nonetheless, appropriate treatment would

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				years prior but unsure re treatment history. No written documentation available for verification. Allergy: Penicillin – from skin prick testing in China (verbal report from patient only) **Management** • Interpreter used to explain results likely consistent with either past treated syphilis or late latent syphilis. However, as no previous results for comparison and client is pregnant, the lowest risk would be to treat her as LL syphilis. • The gold standard treatment for LL syphilis is benzathine penicillin 1.8g (2.4M units) every 7 days for 3 doses. Penicillin is also a Pregnancy Category A drug and has been used in many pregnant women with no reported adverse outcomes. • As her penicillin allergy has not previously been documented as anaphylaxis, it would be appropriate to refer her to tertiary Immunology team for penicillin desensitisation prior to administration of benzathine penicillin. • Unfortunately, neither she nor her partner attended pre-arranged follow up appointments for partner testing and client referral. She was also not contactable by phone. She was placed on results/reminders protocol for follow up. This is important as syphilis in pregnancy is a treatable condition which can prevent MTC and development of congenital syphilis. The client was tracked down through her antenatal care appointment and handover was given to the high-risk midwife to ensure appropriate LL syphilis treated would be completed.	reduce the MTC risk entirely. Testing and treating the partner is important to prevent reinfection. Current STI guidelines recommend testing at first antenatal visit and at 28-32 weeks. If a woman is at higher risk (e.g. partner not tested/treated, ATSI), then additional testing during pregnancy is recommended. There are Australian consensus ATSI testing guidelines for syphilis in pregnancy. • It is important to liaise with multidisciplinary teams (e.g. GPs, midwives, obstetricians) and other agencies (e.g. public health units) to ensure that syphilis in pregnancy cases are treated & followed up appropriately. If further escalation was required in this case, then we could have enlisted assistance from the local public health unit.
3.	10/2	53	Contraception, Menopause management with 50mg LNG IUD and	**Clinical details** • 53F for HRT review. Mirena inserted for irregular heavy periods age 49. Amenorrhoeic since Mirena inserted, no IMB/PCB/other PV symptoms. Last CST in date + no HPV detected. Rescreen in 5 years as per NCSP guidelines. Using estrodiol 50mcg/25hr patches with LNG-IUG for HRT.	• Menopausal hormone therapy (MHT) benefits outweigh the risks for most symptomatic women. The use of transdermal methods reduces the risk of VTE vs oral formulations. In addition, micronized progesterone may also be

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			estrodiol patches	Initially started 2 years ago for hot flushes, insomnia and fatigue. Very happy with current HRT regime and seeking advice re when to change Mirena as she read information that it can be used for 7 years. **Management** • Reviewed menopause symptoms using Australian Menopause Society symptom score card (https://www.menopause.org.au/hp/information-sheets/ams-symptom-score-card) – no issues were highlighted. • Reviewed cardiovascular disease and osteoporosis risk. To continue regular exercise, maintain normotension and aim for normal BMI. • For osteoporosis prevention in women ≥50 years, ensure dietary calcium intake of 1300mg daily, Vitamin D 1000 units PO daily (if levels low) and weight bearing exercises. • Recommended annual fasting lipids, HbA1c and BP checks annually (at minimum). • Reviewed application technique of estradiol patches and if any barriers to adherence. Repeat script given with ongoing advice that HRT should be used at the lowest dose for symptom control for the shortest amount of time needed to ensure least CVD, VTE and breast cancer risk.	associated with lower risk. In a woman with intact uterus, progestins are required with oestrogen to prevent the increased risk of endometrial cancer when unopposed oestrogen is used. • As per UK FRSH guidelines, 52mg LNG-IUD can be used for endometrial protection for 5 years. The 52mg LNG-IUD can be used for contraception for 7 years if inserted after the age of 46. As the client may have interpreted the information differently, explanation is important so she understands that her 52mg LNG-IUD will need to be changed at 5 years to continue to confer endometrial protection. The 19.5mg LNG-IUD is only licensed for contraception and not for MHT. • For this client, she has had excellent symptom relief from MHT and can continue on it until 10 years post-menopausal where the risks begin to outweigh the benefits. Women on MHT should continue to be reviewed annually for the need to continue MHT.
4.	22/2	29	MTOP Complications – Endometritis, Contraception	**Clinical details** • 29F G2P1T1 non-Medicare eligible client, had MTOP at 7w3d 3/52 ago and presents for MTOP follow up today. She did not undertake an STI screen due to costs. Day 7 post-MTOP, she had >80% serum bHCG from baseline with appropriate bleeding on Day 3. Today, she reports continuous PV bleeding for the last 2/52 with significant malodour. She is changing pads 3-4 hourly for hygiene and reports vulval itch and discomfort. She is also upset as she has limited funds for ongoing medical care.	• Endometritis is an infection of the endometrium associated with pregnancy. It can extend into the myometrium and progress into the abdominal cavity causing peritonitis. The infection is usually polymicrobial. In TOP, the uterus has had a pregnancy so treatments for non-severe postpartum endometritis (ref eTG) are appropriate for endometritis in post-TOP clients.

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				Management • OE client was afebrile, looked well. Abdo SNT. Mild vulval erythema with scratch marks consistent with possible contact dermatitis. Speculum exam NAD with no products visualised in cervical os. No discharge in vaginal vault. Bimanual exam NAD with nil cervical motion or bilateral adnexal tenderness. • Investigations initiated: HVS MCS + Cervical PCR sample for Chlamydia, gonorrhoea and mycoplasma genitalium. • Impression: possible non-severe endometritis • Treat with amoxicillin+clavulanate 875+125 mg orally 1 tablet PO BD and Metronidazole 400mg 1 tablet PO BD – both for 7 days. • STI testing – negative. HVS – BV. • Client improved post treatment and was advised of BV result. Explained that she is on treatment for BV and malodourous symptoms should improve. • Client has not decided on contraceptive option post-TOP. • If unsure re final contraception choice, encourage to use barrier contraception while deciding to prevent unplanned pregnancy & STI transmission. • For review of symptom improvement in 1/52.	• In non-severe postpartum endometritis, infection tends to be localised without systemic features. The treatment is amoxicillin+clavulanate 875+125 mg orally 1 tablet PO BD and Metronidazole 400mg 1 tablet PO BD – both for 7 days. If the client has severe postpartum endometritis with systemic symptoms, then a referral for specialist review in hospital is required. • The client had some financial barriers to care as she is non-Medicare eligible which may have prevented her from seeking medical review earlier. It is important to emphasise to clients that the MTOP process can have complications which need further medical management and may incur costs beyond the initial fees for assessment, provision and minimum follow up. • Non-Medicare eligible women can be subjected to higher contraception costs. For non-PBS subsidised contraception options, they are at the same cost regardless of Medicare eligibility. These options are male/female condoms, diaphragms, vaginal ring, some COCP, POP drospirenone 4mg, and Cu-IUD. However, LARC options like the contraceptive implant and the 19.5mg and 52mg LNG-IUD are a high private prescription price which can be a barrier for women if that is the option most acceptable and suitable for their circumstances. Appropriate counselling and risk/benefit stratification should be conducted to allow women to decide on the most

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					financial/medical/socially acceptable contraception choice.
5.	9/1	45	Permanent (male) contraception counselling and referral	**Clinical details** • 45M attends for vasectomy counselling and referral. • BG Family is complete. Wife 36yo G4P3 has had side effects with various LARC. **Management** • Explore client's reasons for vasectomy. • Counsel that the vasectomy is surgical procedure that results in permanent sterilisation of a man, preventing them from fathering children. • It involves cutting +/- removing a piece of the vas deferens which is the tube linking the epididymis to the ejaculatory duct. • With this procedure, sperm is no longer able to be ejaculated • It is a very safe, 99.5% effective, reliable and permanent method of contraception. • Advise that the female equivalent is tubal ligation, which is more complicated, expensive and invasive than vasectomy. • Most vasectomies are requested by men who have had children and have completed their families. • It does not affect libido, sex drive, ability to get an erection or ejaculate. • It can be done by some general practitioners, general surgeons and urologists. • The procedure is usually a day procedure – under local/general anaesthetic. • Advise that sperm remain in the reproductive system for some months, so contraception (e.g. condoms) should be used until semen analysis at 3 months is done • At 3 months, semen analysis can confirm there are no sperm in the ejaculate	• 2 forms of permanent contraception – vasectomy (male sterilisation) and tubal ligation (female sterilisation). • The similarities are permanent, involve surgical procedure to block transport of sperm/egg, good counselling and information needed, decision made without other pressures (e.g. stress, reproductive coercion), and confidence that the family is complete/no children desired. • Tubal ligation is done via laparoscopy under general anaesthetic. The fallopian tubes are cut and then closed with clips or with ties to prevent transport of the egg from the ovary to the uterus. It will also prevent contact of sperm with egg as the fallopian tube is now cut. It works immediately as a contraceptive and is more than 99.5% effective. However, it does not confer protection to STIs, and barrier protection (condoms) is still recommended for this. As the surgery is at the fallopian tubes, there will be no changes to menstrual cycles and there is no effect on sexual intercourse/libido. If pregnancy occurs, there is a higher risk of ectopic pregnancies with/after tubal ligation. If reversal is desire, about 50% of women can fall pregnant and pregnancies are at higher risk of being ectopic. • Vasectomy has been discussed above in management. • Male contraception is an evolving area of research. Typically, females have had the

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				• For semen analysis, abstain from ejaculation for 2-7 days, collect the semen by ejaculation into the container provided and deliver within 1hr to the nearest lab without refrigeration. • Advise that a vasectomy is considered irreversible, but sometimes reconnecting the vas deferens can return fertility. • Provide some information and offer time to consider decision as it is considered irreversible. • Advise this procedure does not confer STI protection so barrier protection should still be used for this purpose. • Refer to vasectomy provider for further assessment and procedure consent.	contraceptive responsibility, and the vast majority of contraceptive methods are targeted at the female reproductive tract. Ongoing research into hormonal approaches have been met with a few issues, including effect on testosterone level and possibly libido. There is some ongoing research between National Institute of Child health and Human Development (NICHD) and the NGO Population Council to use a novel progestin, segesterone acetate, with testosterone to lower sperm count but maintain testosterone levels is undergoing clinical trials. Further research is also being conducted on reversible non-hormonal options.

6.	30/1	28	Contraception, intellectual disability	**Clinical details**
				• 28F G0P0 with mild intellectual disability living in a group home. Has heavy periods lasting 5-7 days with flooding and passing clots. Requests Mirena IUD as she has heard that it causes amenorrhoea or lighter periods. Not currently sexually active.
				
				Management
				• Engage and assess capacity to consent – flag to client that multiple visits and counselling may be required.
				• Confirm with client and group home carer/staff that no guardianship involved and that client is able to consent independently
				• Review and exclude medical causes of HMB (e.g. hyperthyroidism)
				• Offer and consent for CST – if under screened
				• Good opportunity to assess client's ability to tolerate a speculum exam and to frame the process for awake insertion of IUD.
					• When treating people with a disability, it is important to consider capacity to consent.
					• As per the NSW Health Consent to Medical and Healthcare Treatment Manual, a person has decision making capacity if they can:
					  ○ understand the facts and choices involved
					  ○ weigh up the consequences
					  ○ communicate their decision.
					• By law, "reasonable adjustments" must be made by health care services to facilitate inclusive and accessible services to people with a disability. Information should be provided in simple, easy to understand format (e.g. pictures, simple language, large print, using colour blind friendly palette for resources).

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				• Advised for TA/TV pelvic US to exclude structural causes of HMB • Trial non-pharmacological therapy while pending investigation and further consultations to assess understanding of IUD process and ability to consent. • Use clear and easy to read resources to explain the above • If client is uncomfortable with speculum exam, may offer sedation for IUD insertion or offer nitrous oxide/methoxyflurane if available for non-sedation insertion	• If this client desired to have an IUD inserted without sedation, the health care service can offer nitrous oxide (if available). Alternatively, a methoxyflurane inhaler can be offered by private script and used in the outpatient clinic setting. 52mg LNG-IUD is an effective option for menstrual management due to the high rates of amenorrhoea and can be inserted anytime from menarche. It is also reversible and can be removed easily if the client wishes to conceive in the future. • The same principles applied in this case can be applied across other reproductive and sexual health issues. An example is consent. It is important to ensure that clients are assessed for their ability to consent to sexual intercourse, that they are aware of the risks of pregnancy/STI transmission and that there is no reproductive coercion or power issues in the reported relationship. A risk assessment should be done. If the client is at risk, the clinician's concerns can be communicated in simple, easy to understand language to engage and educate the client. • Additional resources to assist in working with people with a disability are available from Family Planning Australia at https://www.fpnsw.org.au/who-we-help/disability/disability-resources.
7.	4/5	37	Transman for contraception, discussion	**Clinical details** • 37 FTM on daily PrEP for contraception option advice and management.	• Access to gender affirming hormone therapy for trans, gender diverse and non-binary (TGDNB) people can reduce rates of

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			around theoretical increased IUD perforation risk due to uterine atrophy from testosterone	• BG On transdermal testosterone for masculinizing hormone therapy. Amenorrhoeic for last 3 years. Had top surgery. Has not undergone hysterectomy or bilateral oophorectomy. Has previously had cis-female partners but now has trans female partner. They engage in penile-vaginal intercourse. **Management** • Advise that gender-affirming hormones, including testosterone, are not reliable contraception. • Amenorrhoea does not indicate non-ovulation and breakthrough ovulation on testosterone can occur. • For this client, there is still a risk of pregnancy. • In addition, pregnancy is an absolute contraindication for testosterone therapy as it can be associated with teratogenicity (masculinisation of a female foetus). • Client is concerned that contraception will interfere with their masculinizing treatment characteristics. • Advise that POP options are not considered to interfere with hormone regimens for trans and non-binary people. LNG-IUD can support ongoing amenorrhoea – which can be desirable for transmen. • Combined hormonal contraception options that contain both oestrogen & progestogen undergoing testosterone therapy is not recommended as it can counteract the masculinising effects of testosterone. • Options: Non hormonal (condom, diaphragm, Cu-IUD, permanent contraception with tubal ligation) and progesterone only (LNG-IUD, depot, contraceptive implant, oral POP). • Advantages/disadvantages discussed with respect to client's specific requirements • Client opted for 52mg LNG-IUD to support ongoing amenorrhoea to reduce menstrual distress and provide reliable LARC	suicide and improve mental health outcomes. Providing inclusive trauma-informed holistic medical care that recognises the unique needs of TGDNB people can improve their physical and mental health outcomes. TNGBD people experience higher barriers to contraception advice and access. • For this client, it is important to advise that testosterone as masculinizing therapy in gender affirming care is not a reliable form of contraception as ovulation can occur. Amenorrhoea is a desirable side effect for transmen as it reduces gender dysphoria and body dysmorphia. As testosterone has an associated risk of teratogenicity in female foetuses, reliable effective contraception is critical as prevention. • As per UK FRSH statement on "Contraceptive Choices and Sexual Health for Transgender and Non-binary People" (2017), the main appropriate contraceptive options are progestogen only and non-hormonal so as to reduce interaction with testosterone masculinizing hormone therapy. Informed decision making with the client is beneficial to encourage effective engagement with the contraception option. As mentioned, as amenorrhoea is a desired side effect, 52mg LNG-IUD may be the contraception of choice as it has higher rates of amenorrhoea. • All IUD insertions confer a risk of perforation at about 1 per 1000 insertions, with less occurring with more experienced

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				• Important to advise that prolonged testosterone use is associated by uterine atrophy but there are limited studies on this. • Discuss risk/benefit of having IUD inserted by O&G or other experienced IUD inserter to reduce the risk of perforation. • Client agreed to be referred to the tertiary hospital gynaecology clinic for high-risk IUD insertion. • Advice given re ensuring no pregnancy when IUD inserted - suggest abstain from sexual intercourse for the preceding 3 weeks with a negative pregnancy test prior to IUD insertion.	inserters. There are increased risks in the post-partum period up to 9 months and with 6.1 times increase in those who are breastfeeding. It is possible that perforation risk can occur in other situations of uterine atrophy e.g. testosterone use in gender affirming therapy. There are limited studies around this. However, due to the theoretical risk increase, it would be worthwhile to consider IUD insertion by a more experienced inserted (e.g. O&G) in a tertiary clinical setting (if accessible). If not accessible/possible due to rurality/regionality of the client, then the appropriate risk should be communicated to the client, and additional follow-up including TA/TV Pelvic US should be conducted to assess that perforation has not occurred. • The majority of perforation are not detected at time of insertion. Perforation can occur in other non-higher risk situations, so it should be considered if: • Uterine length sounds to >10cm • Unexpected bleeding from cervical os at time of insertion • IUD threads cannot be seen • Persistent unexpected pain +/- bleeding post insertion • Threads are visible but IUD cannot be visibly removed • Pregnancy occurs • (Ref FPAA Statement. Intrauterine Device Malposition and Perforation. 2022. https://shvic.org.au/assets/resources/IUD-

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					Intrauterine-device-malposition-and-perforation-March23.pdf)
8.	24/1	21	Emergency contraception post sexual assault	**Clinical details** • 21yo Australian-born female presented following sexual assault 24 hours ago. Non-consensual penile-vaginal penetration with no condom used. The person was known to her. She did not want a forensic exam or police involvement. She was not on hormonal contraception and had no significant past medical history. BMI was within normal range. **Management** • Emergency contraception was discussed. LNG-EC 1.5mg was prescribed as this was stocked at the clinic pharmacy and the patient did not want to attend an outside pharmacy. Potential hormonal side effects were discussed including spotting and irregular bleeding. An appointment was made for the patient to return to discuss ongoing contraceptive options.	• Emergency contraception is a key concept that needs to be addressed in a sexual assault consultation. There are two oral options — LNG and UPA — as well as the copper IUD. UPA is slightly more effective than LNG and can be taken up to 5 days post-intercourse. LNG-EC 1.5mg can be taken up to 96 hours post-intercourse, though 72-96 hours is off-licence. It works by delaying ovulation and impeding follicular development and only works if taken before the LH surge. It is thought to prevent 64-90% of pregnancies. A double dose should be considered if BMI >30 or if the patient is on liver enzyme inducers including NNRTIs or ritonavir, though the copper IUD is preferred in these women. UPA 30mg can be taken up to 120 hours post-intercourse and is more effective than LNG as it can delay ovulation even after the start of the LH surge. If starting hormonal contraception after UPA, the patient needs to wait 5 days. The copper IUD is the most effective option, can be inserted up to 5 days post-intercourse or 5 days post-ovulation, and is the only option that provides ongoing contraception. It is the best option for women on liver enzyme inducers and for women with BMI >30. With all options, a repeat urine bHCG should be done at 3-4 weeks.

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					References 1. Contraception: An Australian Clinical Practice Handbook 4th edition *https://tgldcdp.tg.org.au/searchAction?appendedInputButtons=contraception.*
2.	9/2	34	Irregular bleeding	• 34yo Aboriginal female presenting with secondary amenorrhoea. She had regular periods until age 22, then irregular cycles every 6-8 weeks. Period cessation correlated with weight gain. She also reported acne and hirsutism. Current weight 70kg. **Management** • STI screen and pregnancy test performed. Bloods taken for LH, FSH, prolactin, testosterone and SHBG. Results showed a high LH:FSH ratio and increased SHBG consistent with PCOS. The patient requested a pelvic ultrasound which was arranged and showed bilateral >12 follicles, consistent with PCOS. COCP commenced. Lipids and HbA1c added. Referred to GP for ongoing annual cardiovascular screening and monitoring.	• Secondary amenorrhoea is defined as the absence of menses for more than 3 months in women who previously had regular menstrual cycles. The differential includes hypothalamic causes such as nutritional deficiencies, excess exercise and stress, pituitary disease including prolactinoma and Cushing's, premature ovarian failure, PCOS, hypothyroidism, and uterine adhesions. Pregnancy is the most common cause and must always be excluded first. Investigation should include bHCG, LH, FSH, prolactin, oestrogen, TSH, and testosterone if hyperandrogenism is present. In PCOS, the pattern is typically low-normal FSH with a high LH:FSH ratio. A patient can meet diagnostic criteria without needing an ultrasound, though it was offered here given the patient's preference. PCOS has long-term metabolic implications including risk of T2DM and cardiovascular disease, which is why ongoing GP monitoring including fasting lipids and HbA1c is important. **References** 1. Contraception: An Australian Clinical Practice Handbook 4th edition *https://tgldcdp.tg.org.au/searchAction?appendedInputButtons=contraception.*

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3.	25/11	14	Implanon insertion	**Clinical details** • 14yo female referred from youth services. Currently has one male regular partner, and one prior male partner. Sexually active with her current partner only and not using condoms. Regular periods. PMH of anxiety and depression, on sertraline, known to Headspace. Attends with her mother, who waited in the waiting room during the consultation. Mother was not aware the patient was sexually active. **Management** • Patient was seen alone first. LARC was recommended as the preferred contraceptive option. Patient was happy to trial the Implanon, and side effects were discussed. STI screen performed and insertion booked. On the day of insertion urine bHCG was negative. Implanon was inserted on day 5 of menses without complication and was immediately effective. Repeat bHCG given to do at home at 3 weeks. Mother was brought into the consultation at the end. Regular STI screening discussed.	• This case highlighted the importance of Gillick competency and seeing patients alone. The mother described the situation as "not happy but this is disaster management," reflecting the patient's responsibility for her own sexual and reproductive health.