

A GLIMPSE INTO A DAY OF WOMEN'S HEALTH CARE

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OBJECTIVES:

- ✘ Know who should be screened and implement current screening guidelines into practice if applicable.
- ✘ Describe the evaluation and management of women presenting with vulvovaginal complaints.
- ✘ Review the basic investigation of abnormal uterine bleeding in reproductive age women
- ✘ Use tips to work efficiently not harder to care for a patient(s).

ABNORMAL PAPS

LESSONS LEARNED:

- ✗ Screening leads to treatment
- ✗ Treatment = COST
- ✗ Long term HPV infection and manifestation is the problem—not transient infection.
- ✗ Overtreatment is not good.

ASCCP GUIDELINES 2012

- ✗ “Recommendations aim to reduce harms without reducing benefits of screening”
- ✗ Guidelines developed to address cervical cancer screening in the general population.
- ✗ Guidelines not intended for women with a history of cervical cancer, exposure to DES in utero, or women who are immune-compromised (e.g. HIV+).

ASCCP GUIDELINES 2012

- ✗ No screening before age 21.
- ✗ 21-29→Pap test alone every 3 years.
- ✗ 30+→Pap test plus HPV every 5 years (or pap test alone every 3 acceptable).
- ✗ No screening after age 65 with at least 3 consecutive negative Pap tests OR at least 2 negative HPV tests in the last 10 years.

ASCCP GUIDELINES 2012

- ✗ Women age 65+ with a history of CIN2 or greater should continue “routine” screening for at least 20 years.
- ✗ No screening post hysterectomy and no history of CIN2 or greater.
- ✗ Guidelines same for vaccinated and unvaccinated women.

ASCCP GUIDELINES 2012

- ✖ No annual screening. (exception HIV every 6 months for 2 years then yearly)
- ✖ ASCUS Pap with negative HPV should be screened again with cotesting in 3 years (Pap test alone 1 year, age 21-29).
- ✖ Negative Pap with HPV+ can either be rescreened with cotesting in 1 year or specifically tested for HPV 16 and 18.

QUESTION#1:

- × **19 yo G1P0 presents for first pap. Sexually active since age 17 with multiple partners. What is the next step?**
- × **A) Colposcopy**
- × **B) Pap**
- × **C) Cotesting (pap/HPV)**
- × **D) Screen for STIs**

WHAT'S NEW? WITH GUIDELINES

UPDATED CONSENSUS GUIDELINES (2013)

- ✗ Discordant co-testing results
- ✗ Unsatisfactory Pap results
- ✗ Normal cytology but insufficient endocervical component
- ✗ Women 21-24 yo
- ✗ Young women

DISCORDANT CO-TESTING RESULTS (WOMEN > 30 YO)

- ✖ HPV+/Pap – (repeat cotesting 1 year) (if both co-tests negative, repeat cotesting 3 years)
- ✖ HPV-/ASCUS (cotesting 3 years)
- ✖ HPV-/LSIL (cotesting 1 year)
- ✖ HPV-/HSIL or ASC-H = Colposcopy
- ✖ HPV-/AGC = Colposcopy (+/- endometrial sampling if indicated)

UNSATISFACTORY PAP RESULTS

- ✗ Repeat cytology in 2-4 months
- ✗ If pap unsatisfactory x 2 = Colposcopy

NORMAL CYTOLOGY BUT INSUFFICIENT ENDOCERVICAL COMPONENT

- ✖ 21-29 yo → routine screening with cytology in 3 years (HPV testing is unacceptable)
- ✖ 30+ → cotest with HPV, if HPV- , then routine screening in 5 years, if HPV+, then cotesting in 1 year, if no HPV, then repeat pap 3 years.

WOMEN 21-24 YEARS OLD

- ✗ Low risk for invasive cervical cancer but high risk for HPV exposure/associated lesions.
- ✗ Annual incidence of cervical cancer 1.4/100,000.
- ✗ No paps before age 21!!!!
- ✗ ASCUS or LSIL → repeat pap yearly for 2 years (colposcopy for HSIL at 1 year or persistence of ASCUS or greater at 2 years)

WOMEN 21-24 YEARS OLD

- ✗ HPV triage is NOT recommended (if done and negative, repeat pap in 3 years, if done and positive, yearly cytology x 2 years).
- ✗ ASC-H or HSIL = Colposcopy
- ✗ See and treat is unacceptable
- ✗ CIN3 (women of any age) = treatment

YOUNG WOMEN

- ✘ Any women who after counseling, consider the risk of future pregnancies from treating cervical abnormalities to outweigh risk for cancer during observation of those abnormalities.

ADENOCARCINOMA IN-SITU

- ✗ Management recommendation =
Hysterectomy (preferred treatment).

QUESTION #2:

- ✗ Which of the following statements is TRUE?
- A) ALL WOMEN HAVE A PAP TEST YEARLY.
- B) Absolutely, no more paps after age 65.
- C) ALL WOMEN SHOULD HAVE AN HPV TEST YEARLY.
- D) WOMEN 30+ ARE COTESTED EVERY 5 YEARS.
- E) NO IDEA, NEED TO BUY THE PAP APP FOR MY SMARTPHONE.

KEY POINTS/SUMMARY:

- ✗ **Do not screen before age 21**
- ✗ **Screen every 3 years between age 21-29**
- ✗ **Screen every 5 years after age 30 (cotesting preferred)(if using pap only then screen every 3 years)**
- ✗ **Stop screening after age 65 (and after hysterectomy for benign disease if no CIN2+)**

KEY POINTS/SUMMARY:

- ✗ **Repeat unsatisfactory cytology even if HPV-**
- ✗ **Missing endocervical component then check age to determine when to recheck and HPV only for 30+**
- ✗ **Follow HPV- and ASCUS at 3 years not 5 years**
- ✗ **“Young” varies by reproductive desires**

MAMMOGRAMS

SCREENING RECOMMENDATIONS

- ✕ ACS and ACOG recommend starting routine screening at age 40.

VULVAR AND VAGINAL CONCERNS

DYSPAREUNIA:

- ✗ **Recurrent or persistent condition characterized by pain or discomfort that occurs as the result of intercourse.**

CAUSES OF INSERTIONAL DYSPAREUNIA

- × **Candidiasis**
- × **Herpes**
- × **Vaginal atrophy**
- × **Vestibulitis**
- × **Radiation**
- × **Topical irritants**

CAUSES OF DEEP DYSPAREUNIA

- × **Pelvic Inflammatory Disease**
- × **Pelvic Surgery**
- × **Endometriosis**
- × **Pelvic Tumors**
- × **Irritable Bowel Syndrome**

DYSPAREUNIA TREATMENT

- ✗ **Aimed at correcting organic cause (eg. Estrogen cream for atrophy, surgical ablation for endometriosis)**
- ✗ **With untreatable organic factors emphasis on adaptation (changing intercourse position or relying on noncoital sexual expression)**

VAGINISMUS

- ✗ **Involuntary spasm of the vaginal musculature interfering with vaginal penetration.**
- ✗ **May be initiated by a physical or psychological cause**
- ✗ **Intensified/perpetuated by pain-tension-pain cycle**

VAGINISMUS TREATMENT

- ✦ **Relaxation techniques (systematic desensitization of vagina with graduated dilators) (emphasis on allowing woman to control pace and duration of sexual activity)**
- ✦ **Vaginismus.com (information site, sells dilators)**

VULVOVAGINAL COMPLAINTS

- ✗ **Accurate diagnosis (despite patient insisting on phone approach, inform “phone is neither a diagnostic nor a therapeutic tool”).**
- ✗ **Phone diagnosis is only marginally better than random chance!**
- ✗ **Women who self treat with OTC (antifungal) are correct 1/3 of the time despite history**

VAGINITIS

- × **Represents $\frac{1}{2}$ of all outpatient female visits**
- × **Most common self referral complaint**
- × **40% of all vulvovaginal problems**

COMMON CAUSES OF CHRONIC VAGINITIS

- × **Contact dermatitis**
- × **Recurrent candidiasis**
- × **Atrophic vaginitis**
- × **Vulvar vestibulitis**
- × **Lichen simplex or sclerosus**
- × **Bacterial vaginosis**

COMPLEXITIES OF CARE “DOWN THERE”

- ✗ Among the “TOP 10” reasons for seeking care from general practitioners**
- ✗ Most common complaint = “yeast infection”**
- ✗ Hygiene routine often deeply ingrained by mother (douching, washing frequency, products used [detergent, soaps, feminine hygiene products])**

EVALUATION

- × **History and physical**
- × **pH testing (3.8 to 4.5 during reproductive years and ≥ 4.7 premenarche and postmenopausal)**
- × **Whiff test**
- × **Wet prep**
- × **Consider cultures and biopsy**

WHEN TO BIOPSY

- ✖ **Anytime you are unsure of the diagnosis!**
- ✖ **R/O cancer or dysplasia (presumed warts that fail to respond to 2-3 office treatments, vulvar changes that do not respond to medical therapy, appearance concerning for neoplasia)**

DISCLAIMER

- × **Limited “research” regarding vulvar vaginal disorders (esp. treatment and outcomes)**
- × **Nothing “FDA” approved for treatment (excludes infectious and atrophy) = “off label use”**

VAGINITIS

- × **History (will self-diagnosis/self treat)**
- × **Discharge (quality, color, consistency, odor, discomfort, duration)**
- × **Estrogen status**
- × **Timing of symptoms (acute, chronic, recurrent)**
- × **Sexual practices**
- × **Medical and medication history**
- × **Hygienic practices**

CONTACT DERMATITIS

- × **Vulvar burning/irritation**

- × **CC = “yeast”**

- × **Hygiene**

 - #1 = irritants**

 - Menstrual hygiene**

 - ?bathing issues**

 - Deeply ingrained (“reports no problems in the past”)**

CONTACT DERMATITIS TREATMENT

- × **Stop offending agent**
- × **Soaks (baking soda—lukewarm water, with 4-5 tablespoons of baking soda, 1-3 times a day for 10 minute)**
- × **Daily skin protection (vaseline)**
- × **Topical steroid ointment (low to medium potency, can use OTC cortisone 10 ointment)**
- × **Education**

LICHEN SIMPLEX

- × Eczema**
- × Unrelenting itching**
- × Clinical diagnosis**
- × MUST break nocturnal scratching cycle**

lichen simplex treatment

- × Improve skin barrier function**
- × Reduce inflammation (stop excessive hygiene, avoid irritants [perfumes, dyes])**
- × Soaks (soothing, promotes circulation, cleans)**
- × Daily skin protection (vaseline, veg. oil)**
- × Identify and treat co-existing conditions**

BREAKING THE “ITCH-SCRATCH” CYCLE

- × Tricyclic antidepressants (eg. Amitriptyline 10 mg 2 hrs before bedtime)**
- × Other night-time option (sedating)
Hydroxyzine (Atarax) 25 mg before bed**
- Day time (consider use of an SSRI since scratching is a form of OCD)**

REDUCE INFLAMMATION

✖ **Topical steroid use (triamcinolone 0.1 % ointment)**

USE → BID x 2 weeks

HS x 2 weeks

M-W-F at bedtime x 2 weeks

RTO 6-8 weeks recheck

LICHEN SCLEROSUS

- × Chronic disease**
- × Biopsy for diagnosis**
- × Vagina is NOT involved**
- × Can occur at any age**
- × Unknown etiology**
- × 5% association with Vulvar Squamous Cell Cancer**
- × Commonest cause of chronic vulvar disease**

LICHEN SCLEROSUS

- ✗ **Chronic Management (wax and waning course—must control pruritis)**
- ✗ **Remove irritants/comfort care/soaks**
- ✗ **Topical steroid ointment (clobetasol and then triamcinolone for maintenance)**

ATROPHIC VAGINITIS

- × **Postmenopausal vaginitis most likely = ATROPHY**
- × **Up to 50% of all postmenopausal women will experience vulvovaginal irritation, soreness, dryness, lower urinary tract problems, and dyspareunia**
- × **Up to 25% of women using systemic hormone therapy will experience urogenital atrophy despite improvement in other menopausal symptoms**

ATROPHIC VAGINITIS TREATMENT

- × **Estrogen**
- × **Comfort measures (moisturizers, lubricants)**

WHAT IS VULVAR PAIN ? “VULVODYNIA”?

- ✗ **Discomfort or pain, characterized by burning, stinging, irritation, or rawness of the female genitals for which there is NO infection or skin disease of the vulva or vagina causing these symptoms.**
- ✗ **Generalized or localized**
- ✗ **Provoked, spontaneous, mixed**

VULVAR PAIN

- × **Prevalence (cumulative life-time incidence 18 % [1 in 6 women in the US])**
- × **Etiology elusive**
- × **Treatment→**
 - comfort care/remove irritants**
 - cool packs for burning**
 - ?diet**
 - medications—No FDA approved treatment**

QUESTION #3:

- × What is the commonest cause of chronic vulvar disease?**
- A) Atrophic Vaginitis**
- B) Bacterial Vaginosis**
- C) Lichen sclerosus**
- D) Chronic dermatitis**

KEY POINTS FOR “DOWN THERE”

- ✗ **Among “Top 10” reasons for seeking care**
- ✗ **Underlying psycho-social concerns (cancer, sex, monogamy, normality)**
- ✗ **Education and reassurance (“time/\$\$\$”) (need to establish realistic expectations)**
- ✗ **BIOPSY if in doubt**

ABNORMAL UTERINE BLEEDING

ABNORMAL UTERINE BLEEDING

- × Any uterine bleeding outside the parameters of normal menstruation in the reproductive years.**

USE OF DESCRIPTIVE TERMS

- × **Cycle regularity** (irregular, regular, absent)
- × **Frequency** (frequent, normal, infrequent)
- × **Duration** (prolonged, normal, shortened)
- × **Volume** (heavy, normal, light)

NORMAL LIMITS

- × **Volume (5-80 ml)**
- × **Frequency (24-35 days)**
- × **Duration (4.5-7 days)**

SYMPTOMS

- × **Heavy or prolonged menstrual flow**
- × **Inter-menstrual bleeding**
- × **Frequent bleeding**
- × **Social embarrassment**
- × **Decreased quality of life**
- × **Sexual compromise**
- × **Alteration in life style**

DIAGNOSIS

- × **Detailed history**
- × **Physical examination**
- × **Laboratory Testing**
- × **Endometrial Sampling**
- × **Imaging of uterine cavity**

PALM COEIN

- × Polyp**
- × Adenomyosis**
- × Leiomyoma**
- × Malignancy/
Hyperplasia**

Coagulopathy
Ovulatory Dysfunction
Endometrial
Iatrogenic
Not yet classified

KEY POINTS FOR AUB DIAGNOSIS

- ✗ **Always exclude pregnancy**
- ✗ **Adolescent girls (most likely anovulation, exclude STIs and vWD)**
- ✗ **Reproductive age women (anovulatory—exclude cancer/pre-cancer if risk factors) (ovulatory—exclude uterine causes fibroids, polyps but most likely idiopathic)**

KEY POINTS FOR AUB DIAGNOSIS

- × **Perimenopausal and postmenopausal women → ALWAYS exclude cancer, if bleeding persists exclude it again, most likely benign causes**

ENDOMETRIAL BIOPSY

- ✗ **Anovulatory uterine bleeding**
- ✗ **Endometrial tissue sampling should be performed in patients with AUB who are older than 45 years of age as first line therapy**
- ✗ **Failed biopsy requires further investigation**
- ✗ **Cancer detection failure rate 0.9%**

ENDOMETRIAL BIOPSY

- ✗ **If patient keeps bleeding despite treatment needs further evaluation**
- ✗ **Generalized endometrial thickening = office biopsy adequate**
- ✗ **Focal endometrial thickening = hysteroscopic directed biopsy**

IMAGING—TRANSVAGINAL ULTRASOUND

- × **Endometrial thickness in postmenopausal women**
 - atrophic 3.4 ± 1.2 mm**
 - hyperplasia 9.7 ± 2.5 mm**
 - endometrial cancer 18.2 ± 6.2 mm**
 - cut off 4-5 mm 95-97% sensitivity**

IMAGING—TRANSVAGINAL ULTRASOUND

× Endometrial thickness in premenopausal women

No established guidelines

Consider biopsy if >45 yo

Consider biopsy in younger women if:

chronic anovulation

diabetes, obesity, hypertension

tamoxifen use

KEY POINTS FOR AUB

- × **1/3 of office visits**
- × **Main reason for hysterectomy**

QUESTION #4:

- ✗ TG is a 28 yo AAF with AUB. Since menarche she has had infrequent or absent menses. She is not using any form of hormonal means to control her periods. Her BMI is 35. Her urine pregnancy is negative. What is your next step in evaluation?**

QUESTION #4:

- A) CBC**
- B) Endocrine evaluation only**
- C) Pelvic Ultrasound**
- D) Endocrine evaluation and endometrial biopsy**



THANK YOU!