Reproductive Care for Women II: Evaluation and Management of Common Reproductive Health Issues

Society of General Internal Medicine Annual Meeting

Chicago, Illinois

Thursday, May 13, 2004
8:00 - 11:30 AM

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Maryann M. Murphy, MD
Summary:

Internists play a critical role in the evaluation of gynecological (GYN) problems. However, GYN issues continue to receive short shrift in many curricula, recent data have challenged the traditional approach to some issues (e.g. menopause management), and new treatment options exist for others (e.g. minimally-invasive radiologic and surgical techniques for the management of symptomatic fibroids). Consequently, clinicians are often unsure how to assess and counsel patients appropriately, and may lack the knowledge and skills to evaluate and manage GYN problems effectively. Using a small group, case-based discussion format, this precourse will review the state-of-the-art, emphasizing cultural competence, current controversies, and future directions.

Attendance at Part 1: Screening and Prevention in Reproductive Health, is also recommended, but not required.

Learning Objectives:

After completing Part 2, participants will be able to (select 4/5 of the following):

3. Describe the evaluation and management of abnormal vaginal bleeding.
4. Describe the evaluation and management of common vulvar disorders, and outline an evidence-based approach to the diagnosis and treatment of vaginitis.
5. List the differential diagnosis of pelvic pain and masses, and describe available treatment options and indications for referral for women with ovarian cysts and symptomatic fibroids.

Agenda:

Small groups of participants will rotate between learning stations, selecting 4/5 to attend.

Time table:

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00-8:10</td>
<td>Introduction</td>
</tr>
<tr>
<td>8:10-8:50</td>
<td>Session 1</td>
</tr>
<tr>
<td>8:50-9:30</td>
<td>Session 2</td>
</tr>
<tr>
<td>9:30-10:00</td>
<td>BREAK</td>
</tr>
<tr>
<td>10:00-10:40</td>
<td>Session 3</td>
</tr>
<tr>
<td>10:40-11:20</td>
<td>Session 4</td>
</tr>
<tr>
<td>11:20-11:30</td>
<td>Wrap up</td>
</tr>
</tbody>
</table>

Part II Breakout Session Choices:

<table>
<thead>
<tr>
<th>Session Choices</th>
<th>Speaker</th>
</tr>
</thead>
<tbody>
<tr>
<td>Menopause Management post WHI</td>
<td>Carol Bates, MD</td>
</tr>
<tr>
<td>Sexual Satisfaction and Dysfunction</td>
<td>Jennifer E. Potter, MD</td>
</tr>
<tr>
<td>Evaluation and Management of Bleeding Disorders</td>
<td>Sara B. Fazio, MD</td>
</tr>
<tr>
<td>Vulvar Disorders and Vaginitis</td>
<td>Michele Coviello, MD</td>
</tr>
<tr>
<td>Pelvic Pain and Masses</td>
<td>Maryann M. Murphy, MD</td>
</tr>
</tbody>
</table>
Menopause Management post WHI
Carol Bates, MD

Goals and Objectives:

1. Discuss the natural history of menopause.
2. Describe risks and benefits of hormone replacement therapy.
3. Describe methods of tapering hormone replacement therapy.
4. Describe treatment options for vasomotor symptoms.
5. Describe treatment options for atrophic vaginitis.

Selected References:

North American Menopause Society www.menopause.org


Menopause Management post WHI
Carol Bates, MD

CASE 1:

A 42 year old woman has been waking from sleep with night sweats for the past month. She has generally had menses every 27 days. For the last 3 months, she has had a 25 day cycle but she has not missed any periods. She is worried that she is entering menopause and requests blood tests and a sleeping pill.

1. Do women develop vasomotor symptoms before menses cease?
2. What is the utility of blood testing in making a diagnosis of menopause?
3. What are the options in managing her symptoms?
4. What should be in the anticipatory “menopausal review of systems?”

CASE 2:

A 56 year old woman transfers her care to you. She had a total abdominal hysterectomy at age 42 for uterine fibroids and has taken conjugated equine estrogens 0.625 mg a day since her surgery. Her gynecologist had suggested that she continue to take estrogen indefinitely though very recently asked her to stop the medication. She experienced frequent daytime hot flashes and night sweats and restarted hormone replacement therapy after 1 week. She is worried about the risk of estrogen and would like to stop estrogen, but is worried about managing her symptoms. She has had a previous bone density with T score of -1.9 at the spine and -1.6 at the hip.

1. What are the risks of estrogen therapy in the absence of progestin?
2. What strategies trigger the fewest withdrawal symptoms in tapering hormone replacement therapy?
3. What will happen to her bone density in tapering estrogen? What should she do to prevent osteoporosis?

CASE 3:

A year later, the same patient is now 57 years old and has successfully tapered off of oral hormonal therapy. She is reporting new dyspareunia and has avoided intercourse. She hates to consider estrogen in any form having worked so hard to come off of the oral estrogen.

1. What are the options in treating atrophic vaginitis?
2. What are the risks of vaginal hormonal therapy?
3. Are there effective treatments for decreased libido?
CASE 4:

A 55 year old woman has been seeing a “holistic endocrinologist” and notes that she is taking “bioidentical” hormonal therapy. She has been assured that this therapy does not confer the risks noted with synthetic therapy used in the Women’s Health Initiative (Prempro: conjugated equine estrogen 0.625 mg qd and medroxyprogesterone acetate 2.5 mg qd). She would like to stay on this therapy indefinitely as she understands it to be risk free. She perceives an improved quality of life on treatment.

1. What is bioidentical hormonal therapy?
2. What are the risks of such treatment?

CASE 5:

A 54 year old woman has had amenorrhea for two years. She is feeling great, but is worrying about her risk of heart disease. She has read of the controversies surrounding hormonal therapy and wonders what is left for her to do to remain healthy?

1. What would you counsel her regarding cardiac risk reduction?
2. What would you counsel her regarding osteoporosis risk reduction?
3. Should she just take raloxifene to reduce her risk of osteoporosis and breast cancer?
Female Sexuality:
Assessing Satisfaction and Addressing Problems
Jennifer Potter, M.D.

Goals and Objectives:

1. Discuss common socio-cultural attitudes about female sexuality
2. Describe the major differences between the male and female sexual response
3. Describe the personal, relational, and physiological determinants of female sexual satisfaction
4. Describe the prevalence, etiology, diagnosis, and treatment of common female sexual concerns

Selected References:


Female Sexuality:
Assessing Satisfaction and Addressing Problems
Jennifer Potter, M.D.

INTRODUCTION:

In preparation for case discussions, please consider each of the following background topics briefly (pertinent didactic information will be presented):

1. Review common socio-cultural attitudes about female sexuality. How is sexuality viewed differently in men compared with women?
2. Review different models of the human sexual response. Which is most apropos for women? What are the major differences between men and women?
3. Review the personal, relational, and physical determinants of female sexual satisfaction. What questions would you ask to assess satisfaction and identify problems in each of these areas?
4. Review the four major categories of female sexual dysfunction as outlined in the 1999 International Consensus Development Conference Classification. What are the limitations of this classification?
5. How common are sexual concerns among women? What is the prevalence of different sexual complaints (desire, arousal, orgasm, pain)?

CASE 1:

A 55 year-old woman reports marital difficulties since her husband began taking Viagra. Previously, they had sex once or twice a month, a frequency that felt right to her. Now he ‘seems to want it all the time’. She feels shy about her body, which she describes as ‘flabby and saggy’. She enjoys sexual activity less due to vaginal discomfort and dryness. She also requires more prolonged stimulation in order to attain orgasm.

1. Does this patient have a sexual dysfunction? If so, how would you define her major problem(s)?
2. What are the causes of decreased libido in women?
3. What additional information would you like to know?

She is postmenopausal (LMP at age 50), healthy, and takes no medications. She describes her husband as ‘a great guy’, and says: ‘I know we need to find a happy medium, but it would be nice to be able to get into having sex once in a while’.

4. What would you look for on physical examination? Diagnostic testing?

On physical exam, she is overweight, and has moderate atrophic genital changes. Her free testosterone level is low normal for a postmenopausal woman.
5. What general recommendations would you make?
6. Do you think ERT/HRT would help her libido? Arousal?
7. What about androgens? What forms are available? Are they effective? Safe?
8. Is there a role for phosphodiesterase inhibitors?

CASE 2:

A 40 year-old woman with IDDM, HTN, and hyperlipidemia describes having had an active, satisfying sexual life in the past. For the last few years, however, though she feels ‘turned on’ from time to time, it ‘just doesn’t seem worth it’ to have sex. Neither self-stimulation nor activities with her partner give her much pleasure: ‘I just don’t seem to feel anything down there anymore.’ Lack of lubrication has also been an issue.

1. How would you define her major problem?
2. What are the causes of decreased arousal in women?
3. What additional information would you like to know?
4. What would you look for on physical examination? Diagnostic testing?

She is premenopausal; menses are normal. Medications include insulin, atenolol, moexipril, atorvastatin, and aspirin. On physical examination, blood pressure is 160/100 and a right femoral bruit is noted. Other than an LDL of 160 and a HgbA1c of 10%, her labs are normal.

5. Are there any further tests that might be helpful?
6. What are her treatment options?
7. Is there a role for phosphodiesterase inhibitors? Are they safe?

CASE 3:

A 35 year-old woman notes difficulty achieving orgasm. She takes paroxetine for mild depression/anxiety. She has no other medical problems and takes no other medications.

1. What are the causes of orgasmic difficulty in women?
2. What additional information would you like to know?

On further questioning, you learn that the problem began six months ago, around the same time that she started the paroxetine. Previously, she was satisfied with her sexual responsiveness. She is in a stable, long-term relationship and has no major stresses. When describing the specific problem, she explains: ‘I feel like having sex, and I get physically turned on when we start to touch, but it takes me forever to come. Sometimes I just get tired of trying and give up.’

3. What is your diagnosis? Is this a common problem? Is her presentation typical?
4. What are her treatment options?
5. How would your recommendations differ if she were on no medications and had never experienced orgasm?
CASE 4:

A 22 year-old woman consults you for evaluation of pain during sexual activity. She says: ‘My fiancé is really upset. Every time we try to have sex, it hurts. I try not to ignore it, but sometimes I get so sore we have to stop.’

1. **What are the causes of painful sex?**
2. **What additional information would you like to know?**

She began to be sexually active in high school, and enjoyed giving and receiving oral-genital sex. She reports a long history of discomfort when inserting tampons, and says that speculum vaginal exams have always been painful. She was a virgin until six months ago, when she began to have intercourse with her fiancé. From the very beginning, she had pain on insertion: ‘Sometimes he can’t even get inside’. With thrusting, she feels a burning sensation in her vagina; it worsens progressively to the point that: ‘I just can’t wait for him to finish’. Water-based lubricants have not been helpful. Though she has not had a vaginal discharge, she tried an OTC anti-yeast cream, which was not effective either. Interestingly, when her fiancé stimulates her orally, she becomes easily aroused, and often experiences orgasm. She describes their relationship as generally supportive, but adds: ‘Lately he’s been getting really impatient with me’. She denies any history of verbal abuse, and has never been coerced to have sex or been physically assaulted.

3. **What would you look for on physical examination? Diagnostic testing?**

On physical examination, her mons pubis and labia are normal. She has minimal erythema at 6 o’clock at the vaginal introitus; this area is hypersensitive on Q-tip testing. The remainder of the pelvic exam is performed with difficulty, due to pain and vaginal muscle spasm on insertion of the speculum and gloved, lubricated finger. There is no vaginal discharge, no vaginal or cervical lesions are noted, and there is no cervical, adnexal, or uterine tenderness.

KOH and wet preps are negative. An HSV culture of the erythematous region shows no growth.

4. **What are her treatment options?**
Evaluation and Management of Bleeding Disorders

Sara Fazio, MD

Goals and Objectives:

1. Describe the differential diagnosis of amenorrhea and dysfunctional uterine bleeding.
2. Describe the diagnostic workup of abnormal uterine bleeding.
3. Describe the approach to uterine bleeding depending on pre, peri, or post-menopausal status.
4. Discuss treatment options for women with bleeding abnormalities.

Selected References:


Cann CE, Martin MC, Genant HK, Jaffe RB. Decreased spinal mineral content in amenorrheic women. JAMA 1984; 251:626-29.


Davis, A. A 21-year old woman with menstrual irregularity. JAMA 1997; 277: 1308-14.


Evaluation and Management of Bleeding Disorders
Sara Fazio, MD

CASE 1:

A 25 year-old female presents to your office complaining of heavy bleeding for the past two months. She underwent menarche at the age of 15. Periods were fairly regular until age 23, then became increasingly irregular over the past year and a half. She missed several cycles entirely this year, but over the past two months has noticed that she is bleeding quite heavily, passing clots on occasion.

She is sexually active. She and her partner use condoms as a means of birth control. She has no history of STDs. Denies recent trauma. Notes a thin vaginal discharge. Otherwise ROS is unremarkable.

1. Is there anything else you want to know?
2. What should be done on physical exam?
3. What is the differential diagnosis?
4. What evaluation would you do?

Exam was unremarkable. Uterus was not enlarged. No evidence of hirsutism. UCG negative. TSH, prolactin and cbc wnl, with exception of hct of 24. Progesterone level was 2.0 (second half of cycle).

She is still bleeding fairly heavily.

5. What treatment options do you have?
6. When is a gyn referral necessary?

CASE 2:

A 19 year-old college student presents with oligomenorrhea. Menarche was at age 16, and she had normal cycles until approximately one year ago. Since that time, she has had three periods, the last approximately three months ago. She has a lifetime history of four sexual partners, though denies any activity for the past six months. No history of prior oral contraceptive or Depo-Provera use. She seems to enjoy school but notes that things are “stressful”. She is active with the track and field team. Her mother convinced her to come in today, but she sees no reason for concern.

1. What is in your differential diagnosis?
2. How would you begin the diagnostic investigation?
3. What are the long-term consequences of oligo/amenorrhea in a young woman?
CASE 3:

A 44 year-old woman in your practice comes in to see you for an urgent care visit. She has had normal periods since menarche at age 12. She was on oral contraceptives for 10 years from age 19 to 29, but no recent hormonal therapy. She missed one cycle earlier this year which she attributed to stress, but now has been having a regular period for the past two months every 14 days. She is very anxious.

1. *How would you evaluate her?*
2. *Does she need an endometrial biopsy?*

CASE 4:

A 65 year-old female complains of vaginal spotting. She underwent menopause at age 50.

1. *What is the most likely diagnosis, and what evaluation needs to be done?*
Vulvar Disorders and Vaginitis
Michele Coviello, MD

Goals and Objectives:

1. List the common causes of vaginitis.
2. Recognize dermatologic conditions which affect the vulva and vagina.
3. Discuss an appropriate vulvovaginal evaluation, including vaginal pH, whiff test, vaginal cultures, and microscopy.
4. Describe the management of sporadic and recurrent vaginitis.
5. Describe treatment options for vulvodynia.

Selected References:


Vulvar Disorders and Vaginitis
Michele Coviello, MD

CASE 1:

24 year old G0P0 female in good health presenting with three days of increased vaginal secretions which are noted to be thin and yellow in color. She notes an unusual odor. She denies external irritation, dysuria, itching, abdominal pain, or fever. Her menses are regular and LMP was 3 weeks ago. She has been taking a monophasic low dose estrogen combination pill for the last year. She is in a monogamous sexual relationship with a male partner for the last six months. Her partner is without symptoms. There is no prior history of any vaginal infection.

1. What are the characteristics of physiologic and pathologic vaginal discharge?
2. What are the most common causes of abnormal vaginal discharge?
3. How can one distinguish an upper tract versus lower tract infection?
4. How would the differential diagnosis vary if the woman was in a lesbian relationship?

On exam, no ulcers, fissures or erythema are noted in the vulva. The vaginal introitus, canal and cervix are not erythematous. A moderate amount of thin grey homogenous discharge is pooled in the posterior vagina. Her cervix appears normal. Bimanual exam is unremarkable.

5. How helpful are symptoms and signs in determining the etiology of vaginal complaints?

PH of vaginal secretions is 5.5. A sample of vaginal secretions is prepared with saline and with 10% KOH. A whiff test is noted to be positive for amines.

6. What are Amsel’s criteria for diagnosing bacterial vaginosis?
7. Would a culture of vaginal secretions be helpful?
8. What risk factors are associated with bacterial vaginosis?
9. How should she be treated?
10. How is recurrent disease managed?
CASE 2:

A 38 year old woman presents with three days of vulvar burning which is worse with urination. She denies urinary frequency or any change in the appearance of her urine. She also denies abdominal pain or fever. She notices a small amount of yellow discharge intermittently. Similar symptoms occurred prior to her menses in the last two cycles but seemed to improve after menstruation ceased. LMP 23 days ago. She has been on a monophasic low dose birth control pill for three years. Eight weeks ago she was treated with a fourteen day course of amoxicillin for sinusitis.

She is involved in a monogamous heterosexual relationship. She denies douching. She regularly uses a shower gel and sponge. After drying off, scented body powder is frequently applied.

1. What is the differential diagnosis?
2. Imagine the patient is a postmenopausal woman not using exogenous estrogen. How is the differential altered?
3. What products are frequently linked with irritant vaginitis?

There is no suprapubic tenderness on abdominal exam. Vulvar exam reveals erythema of the labia minora, vestibule, and vaginal introitus. Mild edema of the labia minora is present. A small amount of white discharge is noted to be adherent to vaginal walls. Cervix appears normal. The bimanual exam produces pain at insertion. The remainder of the exam is unremarkable. pH of vaginal secretions is 4.0.

5. What are her risk factors for yeast vulvovaginitis? Do sexual practices matter?
6. How should she be treated?
7. What is the definition of recurrent candidiasis?
8. How is recurrent candidiasis treated?

CASE 3:

62 year old female with vulvar and perianal itching which had been present for at least six months. She denies vaginal discharge, blistering, or vaginal bleeding. She notes dyspareunia with penetration. She and her husband are not sexually active as a result. Menopause occurred at 52. She has not taken any hormones. Her medical history is notable for hypothyroidism for which she takes thyroxine. She denies recent antibiotic use. She showers daily using white Dove soap and a washcloth. No feminine sprays, lubricants, or powders are applied.

1. What conditions cause vulvar itching without discharge?
No skin rash or nail pitting was noted. Her oral mucosa was unremarkable. Hypopigmented areas surrounding the clitoris, upper portions of labia minora, and anus were seen. Fusion of the labia minora and majora evident bilaterally. Few ecchymosis were seen on the labia. No erosions were present. The vagina was pale with slightly decreased rugae. No vaginal erythema was seen. The cervix was pale. Minimal vaginal fluid was seen. Discomfort at the introitus was noted on bimanual exam. Bimanual exam was otherwise normal. The pH of secretions was 5.0. Wet prep with a few parabasal cells. Whiff test was negative. KOH was unremarkable. Vaginal yeast culture was negative.

2. How does one differentiate lichen simplex chronicus, lichen planus, and lichen sclerosus?
3. What other diseases lead to loss of vulvar architecture?
4. How should she be treated?
5. What is the appropriate follow up for a patient with lichen sclerosus?
6. What local measures can be used to alleviate vulvar pruritis?

CASE 4:

A. 25 year old female presents with sharp vulvar pain intermittently over a twelve month period. Inserting a tampon and sexual intercourse provokes the pain. Prolonged sitting or leaning forward while sitting is very painful. Her periods are regular. There is no vaginal discharge. Multiple courses of OTC antifungal creams and oral fluconazole have not changed her symptoms. Exam: Mons, labia majora and clitoris appear normal. The vestibule looks erythematous without edema. The vagina and cervix are normal. Minimal mucous is seen in the vagina. When the vestibule is touched gently with a moistened Q tip, there is exquisite pain. Pain is elicited with insertion of one finger for bimanual exam. Her internal exam is normal.

B. 52 year old woman complains of two years of severe genital burning. Initially, the sensation was of an itching or stinging which affected the entire vulva. Occasionally, the inner thighs were involved. The sensation has gradually become more painful. It occurs daily and then may remit for weeks at a time without explanation. She has taken to wearing flowing skirts as any tight clothing aggravates her pain. She had an uneventful menopause and is not on any hormones. Past history includes mild low back pain due to a herniated disc after a fall ten years ago. She is unable to sit during the interview because of pain. Vulva appears entirely normal. Light touch with a moistened Q tip on the perineum, or even inner thighs leads to intense pain.

1. Do both women suffer from vulvodynia?
2. What are the most common types of vulvodynia?
3. How prevalent is vulvodynia?
4. What are the known triggers of vulvodynia?
5. What other medial problems are commonly found in women suffering from vulvodynia?
6. Does vaginismus play a role in chronic vulvar pain?
7. What treatment options are available?
Goals and Objectives:

1. Discuss the important features of the history and physical exam when evaluating the complaint of pelvic pain.
2. Discuss the ultrasound findings that help to differentiate benign from malignant adnexal masses.
3. Discuss the role of lab tests and serum tumor markers when evaluating adnexal masses.
4. Describe the evaluation and management options of ovarian cysts, uterine fibroids and adnexal masses in postmenopausal women.
5. Describe the incidence and natural history of uterine leiomyomata.
6. Discuss the management of leiomyomata, including surgical and nonsurgical treatment options.

Selected references:

Brown, DL. Sonographic Differentiation of Benign Versus Malignant Adnexal Masses. Up to Date 2004

Drake, JG, Londono, J, Hoffman, MS. Overview of the Etiology and Evaluation of the Adnexal Mass. Up to Date 2002


Nardo, LG, Kroon, ND, Reginald, PW. Persistent unilocular ovarian cysts in a general population of postmenopausal women: is there a place for expectant management? Obstet Gynecology 2003; 102:589


Stewart, EA, Treatment of Uterine Leiomyomas. Up to Date 2004


**CASE 1:**

A 29 year old G1P1 female presents to your office complaining of a several month history of a cramp-like discomfort in her right lower abdomen that seems to occur in the middle of her menstrual cycle. Her last Pap smear was within the past year and was normal, LMP was just over 2 weeks ago.

1. **What should your initial evaluation include?**

Pelvic exam revealed mild fullness over the right adnexa, and ultrasound confirmed the presence of a solitary, thin walled, unilocular cyst, approximately 7cm in diameter.

2. **What treatment can you offer her, and how should you follow this patient?**

**CASE 2:**

A 65 year old female presents for her annual exam. She reports feeling generally well, but has been experiencing some abdominal bloating, which she thinks may be secondary to constipation. Her pelvic exam reveals a palpable left ovary; right ovary is nonpalpable. Her uterus does not feel enlarged, and her cervix is freely mobile.

1. **What aspect of her exam is concerning?**

You order a pelvic exam, which shows a complex left adnexal mass and a small amount of free fluid in the pelvis.

2. **What should you do next?**

3. **If the ultrasound had shown no ascites and a simple left adnexal cyst, how would your management change?**

**CASE 3:**

A 35 year old G0P0 African American female presents to your office complaining of a 6 month history of increasing menstrual flow and cramping. She suspects she may have fibroids, as her mother did when she was younger.

1. **Does this patient have risk factors for developing leiomyoma?**
2. **What is your clinical suspicion for leiomyoma?**
3. **How would you confirm the diagnosis?**
The patient reports she is in a relationship, and uses a diaphragm for birth control. She wonders what can be done to help alleviate her symptoms. She is not interested in having any procedures.

4. What can you offer her?

The same patient presents in follow up 6 months later. She reports that initially her symptoms were improved on the measures you had recommended, but the heavy bleeding and cramping have returned. She reiterates that she does not want any procedures done.

5. Is there any additional medical treatment you can offer her?

CASE 4:

A 44 year old female presents with a several month history of increasing pelvic pain and pressure, dyspaerunia, and menses which, though heavy for at least one year, seem to be getting even heavier. Physical exam confirms the presence of an enlarged uterus of irregular contour. The patient wishes to discuss management options with you.

1. What are the options available to her?

After you have reviewed the options with her in detail, the patient reports that she would like to try the newer, less invasive procedure.

2. What further evaluation is necessary by the primary care physician prior to referral for a UAE procedure?

3. What type of follow up is required for the patient after she undergoes the UAE procedure?