Reproductive Care for Women I: Screening and Prevention

Society of General Internal Medicine Annual Meeting

Chicago, Illinois

Wednesday, May 12, 2004
1:00 - 4:30 PM

Session Coordinator:
Jennifer E. Potter, MD

Additional Faculty:
Carol Bates, MD
Diane E. Krause, MD. MPH
Eileen E. Reynolds, MD
Barbara G. Rosato, APRN, NP
Joyce A. Sackey, MD, FACP
Summary:
Internists play a critical role in the prevention of and screening for reproductive health problems. However, discussing sex and performing a competent pelvic exam can be difficult, reproductive health issues receive short shrift in many curricula, and numerous new diagnostic and treatment options exist. Consequently, clinicians are often unsure how to assess and counsel patients appropriately, and may lack the knowledge and skills needed to provide optimal care. The problem is especially acute for minority and underserved women, who continue to experience disparities in abnormal screening follow-up and prenatal care, and to suffer excess rates of sexual coercion, violence, sexually-transmitted illness, cervical dysplasia, unintended pregnancy, and poor birth outcomes. 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.

Learning Objectives:
After completing this precourse, participants will be able to (select 4/5 of the following):

1. Demonstrate how to take a culturally-sensitive sexual history and provide culturally-relevant safer sex counseling and screening for sexually-transmitted infections.
2. Describe how to perform a competent pelvic exam in women with common anatomic variants, a history of sexual trauma, and physical disabilities.
3. List the pros and cons of new hormonal contraceptives, prescribe emergency contraception, and describe the limitations and benefits of contemporary methods of pregnancy termination.
4. Describe how to assess a woman’s risk for poor pregnancy outcome, provide pertinent education, and institute appropriate interventions before conception.
5. Describe the pros and cons of conventional versus liquid-based cytology systems, indications for HPV testing, and strategies to increase follow-up after an abnormal Pap smear.

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

Time table:

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

Part I Breakout Session Choices:

<table>
<thead>
<tr>
<th>Sexual Risk and Sexual Safety</th>
<th>Jennifer Potter, MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Challenging Pelvic Exam</td>
<td>Carol Bates, MD</td>
</tr>
<tr>
<td>Prevention and Termination of</td>
<td>Diane Krause, MD MPH &amp;</td>
</tr>
<tr>
<td>Unintended Pregnancy</td>
<td>Barbara Rosato, APRN, NP</td>
</tr>
<tr>
<td>Preconception Counseling Pearls</td>
<td>Joyce Sackey, MD</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>Eileen Reynolds, MD</td>
</tr>
</tbody>
</table>
Sexual Risk and Sexual Safety  
Jennifer Potter, M.D.

Goals and Objectives:

1. Demonstrate how to take a culturally-sensitive sexual health history.
2. Describe how to provide culturally-relevant risk-reduction counseling and screening for sexually transmitted infections.

Selected References:

American Medical Women’s Association, Reproductive Health Initiative: Condom Curriculum. www.amwa-doc.org

American Medical Women’s Association, Reproductive Health Initiative: Reproductive Health Curriculum. www.amwa-doc.org


Sexual Risk and Sexual Safety
Jennifer Potter, M.D.

CASE 1:

An 18-year-old immigrant comes to clinic because she needs health forms completed. Prior to seeing her, one of the nurses takes you aside and warns you not to ask the patient about sex, because women in her culture never discuss it.

1. Is it important to gather data about her sexual health? Why or why not?
2. What are the key components of a comprehensive female sexual health history?
3. Discuss personal and cultural barriers to talking with female patients about sex.
4. How would you build rapport with this patient? What questions would you ask to identify the norms/customs surrounding coming of age and being a woman in her culture?

Through an interpreter, you learn that it is expected that women remain virgins until marriage. Therefore, although she dates men regularly, she has never had intercourse.

5. Is there any additional information you would like to know?
6. Does she need a pelvic exam? Screening for sexually transmitted infections (STIs)?

CASE 2:

A 20-year-old new patient sees you for a ‘check-up’. The name on her hospital registration form is Nancy Davis. Her appearance is masculine: short hair, baseball cap, no jewelry, androgynous shirt/pants, and sneakers. Looking further at the form, you note that she did not respond to questions about sex (M/F) and marital status (S,M,D,W).

1. Discuss the meaning of the terms ‘sex’ and ‘gender’.
2. Describe the differences between the following concepts: gender identity, sexual orientation, and sexual behavior.
3. What general questions would you ask to open a discussion about sex?
4. How would you raise the subject of gender identity? Sexual orientation?

During your conversation, you learn that she feels comfortable as a woman, as long as she is able to dress in ‘butch’ clothing. She has recently decided she is gay.

5. Is it important to determine her level of self-acceptance? How would you ask?
6. What general questions would you ask about her sexual behavior?
7. Is she at risk for unintended pregnancy? How would you ask?
8. Is she at risk for sexually transmitted infections? How would you ask?
She started having sex at age fifteen with a high school boyfriend. Since then, she has had 4 partners - 3 men and 1 woman. Sexual activities have included penile-vaginal and -anal intercourse; oral-penile, -vaginal, and -anal sex; and mutual masturbation. With male partners she uses condoms ‘mostly’; she has never used barrier methods during sex with women. She has never been pregnant. She has received treatment for genital warts and cervical dysplasia, and had an isolated outbreak of genital herpes several years ago. Currently, she is dating women, though she remains open to a relationship with a man if ‘an interesting guy were to come along’. She admits that she ‘isn’t sure’ how to discuss safer sex in dating relationships or what methods to use.

9. *Is her history unusual? Why do women take sexual risks?*

10. *What are the relative efficacies of different contraceptive methods? What would you recommend to her now?*

11. *What are the relative risks of various sexual behaviors? What safer sex methods would you recommend to her? How effective are they?*

12. *What are the reasons for poor adherence to safer sex methods (‘barriers to barriers’)? How can you help her negotiate more effectively with partners?*

13. *Which STIs are transmissible between women who have sex with women? What STI screening would you recommend to her now?*
The Challenging Pelvic Examination  
Carol Bates, MD

Goals and Objectives:

1. Discuss current guidelines regarding pelvic examinations.
2. Discuss perspectives on chaperone presence in examinations.
3. Discuss aspects of examination that are uncomfortable, stressful or technically challenging and brainstorm solutions.

Selected References:


The Challenging Pelvic Examination
Carol Bates, MD

CASE 1:

A 23 year old woman presents for an annual examination. She has had normal menses and has no significant dysmenorrhea. She denies any past sexual intercourse. She has never had a pelvic examination.

1. **Should she have a pelvic exam? What are the guidelines?**
2. **What preparation needs to occur before an examination?**
3. **Are there different techniques that you would use in a first pelvic examination?**
4. **Would you have a chaperone present?**
5. **What steps would you follow for a comprehensive pelvic examination?**
6. **What strategies would you use if you have difficulty visualizing the cervix with a speculum?**

CASE 2:

A 45 year old woman comes to see you for persistent cough. In gathering her full history, you learn that she has accessed health care intermittently but has not had a pelvic examination in 10 years.

1. **Why might she have avoided pelvic examinations?**
2. **How can you make examinations easier?**

CASE 3:

A 37 year old woman divulges a history of childhood sexual trauma. She was sexually assaulted as a teen by her aunt’s former husband. She has not discussed this with anyone. She has not been in an adult intimate relationship. She has been avoiding pelvic examinations.

1. **How would you respond to her divulged history of childhood trauma?**
2. **What techniques would you use to make the pelvic examination easier?**
CASE 4:

You are examining a 55 year old woman who is postmenopausal and is not on hormone replacement therapy. You have done several pelvic examinations on her in the past without incident. She winces as you insert the speculum and notes that examination is more uncomfortable than she has previously experienced.

1. Why is the examination suddenly uncomfortable?
2. What can be done to make examinations easier?

CASE 5:

You have started a pelvic examination on a 60 year old Somali immigrant who just became your patient. You are shocked to see extensive scarring in the external genitalia and wonder what happened.

1. What do you think has occurred?
Prevention and Termination of Unintended Pregnancy

Diane Krause, MD, MPH
Barbara Rosato, APRN, NP

Goals and Objectives:

1. Discuss the use and limitations of emergency contraception.
2. Describe options for terminating unintended pregnancy.
3. Describe contraceptive methods available for perimenopausal women.
4. Describe new hormonal contraceptive options.
5. Discuss the advantages and disadvantages of the newer contraceptive choices.

Selected References:

Burkmann, RT et al “Current Perspectives on Oral Contraceptive Use” Am J Ob Gyn 185: (2) 2001


Murphy PA. “New Methods of Hormonal Contraception.” Nurse Practitioner 2003; 28 (2): 11-21


Sulak PJ, Et al, “Acceptance of altering the standard 21-day/7-day oral contraceptive regimen to delay menses and reduce hormone withdrawal symptoms”. Am J of Ob and Gyn 2002; 186:1142-9.


Williams, JK “Contraceptive needs of the perimenopausal woman” Ob and Gyn 29 (3): Sept 2002


Prevention and Termination of Unintended Pregnancy
Diane Krause, MD, MPH
Barbara Rosato, APRN, NP

CASE 1:

A 35-year-old female is seen for her annual physical examination. In addition to her annual screening tests, she would like to discuss newer hormonal birth control options she recently read about in a fashion magazine. She would like to know about “the patch” (Ortho Evra), NuvaRing, Lunelle, and Seasonale. She has been on oral contraceptive pills for 8 years. She is sexually active with one male partner for three years. Other than the OCP, she takes a multivitamin daily. Her medical history is unremarkable.

1. **Discuss the newer hormonal birth control options.**
2. **What are the advantages and disadvantages of these methods?**
3. **What are the contraindications?**

During your conversation, you learn that she and her husband would like to wait a year before attempting to start a family. Upon further questioning, she admits to “socially smoking”, that she defines as 5-10 cigarettes a week.

4. **How do you counsel her about her smoking in regards to concurrent contraceptive use?**
5. **Given your understanding of the newer options, her smoking history and her family planning needs, what would you recommend?**

CASE 2:

A 25 year-old woman calls your office in tears. She explains that she had unprotected intercourse 48 hours previously. She tells you that her periods are regular and she thinks her last menstruation was 2-3 weeks ago. She explains that she is not ready to have a child and is worried that she may become pregnant from this encounter.

1. **What are the chances that she will become pregnant from this encounter?**
2. **What options does she have at this point to decrease her chance of becoming pregnant? How effective are her options?**
3. **Do you need to see her in the office or can you give her advice and treatment over the phone? What adverse effects do you warn her about?**
This same patient calls your office 4 weeks later. She noted a small amount of spotting 2 weeks after using emergency contraception but no real menses. She did a urine pregnancy test at home and it was positive. She again tells you that she is not ready to have a child.

4. What options exist for termination of pregnancy?
5. Briefly explain how medical termination of pregnancy is done.
6. What are the limitations and contraindications to medical termination of pregnancy?
7. What follow up is needed after pregnancy termination?

CASE 3:

An 18-year-old college student presents to your clinic for birth control. Her college roommate currently uses “the shot”. She is a relatively healthy young female with a past history of exercise-induced asthma. She is sexually active and uses condoms consistently.

1. What are the benefits and efficacy of depot medroxyprogesterone acetate (DMPA) injection?
2. What are the disadvantages of this method?
3. In what situations would a progestin only injectable be safer? Would she be a candidate for Lunelle, the combination hormone injectable contraception?

Your patient is 5’4” and weighs 160 lbs. She admits to gaining the “freshman 15” and intends to join the gym.

4. How do you instruct her about DMPA use and weight issues?
5. Are there any other counseling issues you would address?

Three years have passed. Your patient has been seeing you every 12 weeks for her DMPA injection. During that time, she developed amenorrhea after her 3rd dose. However, at today’s visit she reports mild spotting that began two weeks ago for approximately one week.

6. Do you need to further evaluate her vaginal spotting?
CASE 4:

A 47 year-old heterosexually active woman comes to see you for her yearly exam. When you review her history you note that she does not use contraception. She tells you that her periods have become very erratic and that she often goes for 2-3 months without menses. She has occasional hot flashes but no other symptoms of menopause. She has two teenage children and explains that she is not interested in having more.

1. Is she at risk for pregnancy?
2. What options exist for contraception in the perimenopause?
3. What further history would be useful in helping her to decide on a method of contraception?

Her only past medical history is of a fibroadenoma removed at age 30. She has a family history significant for osteoporosis in her mother who is in her early 70s and breast cancer in a maternal aunt diagnosed at age 65. She is a thin, Caucasian woman who exercises regularly and does not smoke. Her last cholesterol profile showed a total cholesterol of 180 with an HDL of 66.

After you discuss the options available to her for contraception she tells you she would like to start on oral contraceptive pills (OCP).

4. What can you tell her about the risks associated with OCP use in the perimenopausal population?
5. What can you tell her about possible benefits of using OCP during the perimenopause?
6. How will you know when she is fully in menopause and no longer at risk for pregnancy if she is using OCPs?
Preconception Counseling Pearls
Joyce A. Sackey, MD, FACP

Goals and Objectives:

1. Discuss the importance of preconception counseling as part of primary, preventive care.
2. Describe an approach to preconception assessment and risk identification.
3. List specific skills in preconception counseling for a variety of clinical scenarios.
4. Discuss specific evidence-based interventions that can be used by primary care physicians to modify maternal risk factors and improve pregnancy outcome.

Selected References:


Preconception Counseling Pearls
Joyce Sackey, M.D.

CASE 1:

A 21 year old woman comes to see you because she thinks she might be pregnant. She reports regular menses and is a week late for her menses. A urine HCG in the office is negative.

1. What additional history would be helpful?

On further history, she tells you that she is not using any form of birth control. She is in a steady relationship over the past year and “won’t mind it” if she were to become pregnant.

2. What important issues need to be addressed on this visit?

3. What recommendations, if any, would you make?

CASE 2:

A 34 year old woman with h/o obesity and Adult-onset Diabetes Mellitus is seeing you for a routine medical follow-up. She is on Metformin and her last Hemoglobin A1c checked 3 months ago was 8.7%. She reports no symptoms other than irregular menses. She is engaged, to be married in 6 months, and is interested in starting a family right away. She would like to discuss her plans for pregnancy with you.

1. What are the key issues that would need to be addressed as part of preconception counseling for this patient?
2. How would you manage this patient’s diabetes preconception? During pregnancy?

CASE 3:

A 39 year old woman is seeing you because she is concerned she has not been able to get pregnant despite consistently trying for 6 months. Past Medical History is remarkable for depression, for which she takes Sertraline. She is a smoker but has been trying to quit because of her pregnancy attempts. She now smokes about ½ pack a day.

1. What additional history might be helpful?
2. What are the health risks in this patient and how might they affect pregnancy?
3. What interventions, if any, would you recommend?
CASE 4:

A 29 year old woman with a history of seizures is seeing you for a routine physical. Her seizures have been well controlled on Tegretol over the past 3 years. Her last seizure episode was a year ago in the setting of a sub-therapeutic Tegretol level. She admitted to non-adherence then but reports that since her last seizure, she has been taking her medication as prescribed. She is on no other medication. She and her husband have a 5 year old daughter. Recently, they have been discussing the possibility of having another baby. She is interested in your opinion as to whether it would be safe to get pregnant given her “medical situation”.

1. How would you approach counseling this patient?
2. What specific recommendations would you make?
Learning Objectives:

1. Describe the natural history of human papillomavirus and of cervical lesions.
2. Describe the epidemiology of cervical cancer.
3. Discuss the best screening tests currently available for cervical cancer.
4. Describe the appropriate guidelines for cervical cancer screening.
5. Describe appropriate management of ASCUS Pap results.
6. Discuss the future directions for cervical cancer screening.

Selected References:


Cervical Cancer Screening
Eileen E. Reynolds, MD

CASE 1:
A 68 year-old woman comes to your office for her annual physical examination. You have known her for many years; she is relatively healthy, but suffers from mild arthritis and obesity. She had an abnormal Pap smear 20 years ago; her subsequent annual smears have been normal, including one collected at last year’s physical. She has been married to her second husband for over a decade, and as far as she knows neither of them has had partners outside their relationship. She has never had a sexually transmitted disease.

1. What is the epidemiology of cervical cancer in the US? In the world?
2. What is the natural history of cervical cancer – how does it develop?
3. When should her next Pap test be performed?
4. What is the harm in doing a Pap smear today if she expects that one be done?

CASE 2:
You meet a 26 year-old for the first time. She has been sexually active with one partner for the past 6 months; before that, she had had 6 partners in the past 2 years. She has never had an abnormal Pap test before, but she hasn’t had one performed in 5 years, because she didn’t have insurance when she graduated from college. She had a cervical chlamydia infection once in her teens; she has never been pregnant. Her last period was two weeks ago and was normal.

1. What is the best screening test for cervical cancer in this patient? (Traditional Pap test, liquid-based prep, HPV test, or other?)
2. What if she had her period today?
3. What if she had a previous abnormal Pap test?
4. What is the appropriate screening interval for her, assuming that this year’s is normal?

You do a traditional Pap test. Her result returns in 3 weeks; she has atypical squamous cells of undetermined significance (ASCUS).

5. What is the natural history of ASCUS?
6. What are your options for further diagnostic testing?
7. How should you follow her up?
8. Does she require referral to a gynecologist, or should she have a colposcopy?
CASE 3:

A 45 year old woman comes in to see you in follow up. She is healthy, and has been getting her gynecologic care from the physician who delivered her twins 10 years ago. She carries with her the results of her most recent testing, done by that gynecologist. She had a normal Pap smear, a negative Chlamydia test, and a positive HPV test.

1. What else do you want to know about her?
2. Should HPV testing be routine and offered to all patients?
3. How do you read an HPV test result?
4. Should it have been done in conjunction with her Pap test, instead of her Pap test, or not at all?
5. Will HPV testing become the standard screening test for cervical cancer?