WELL WOMAN EXAMS IN PRIMARY CARE

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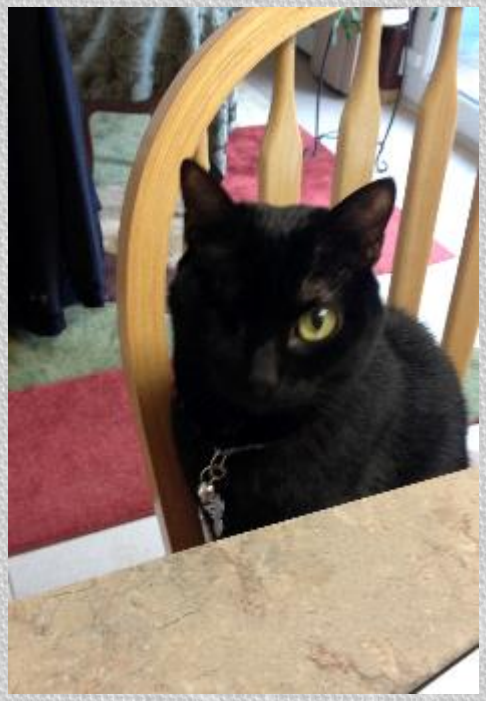
Objectives:

- Develop a systematic approach to the well woman exam.
- Discuss the rationale for the 2012 changes to Pap smear schedule and follow up.
- Navigate available apps for Pap smear interpretation.
- Discuss Pap smear case studies focusing on follow up criteria.

Disclosures:

- I have no disclosures to discuss.



Purpose of Well Woman exam in Primary Care

- For many women, this may be their only visit for health care
  - Opportunity for education!
  - Encourage patient to become familiar with their body

- Health History
  - Reproductive health
  - Sexual health
  - STI/STD screening

- Elements:
  - Physical exam – Head to Toe
  - Pelvic/gynecological exam

Health History

- Current medical issues
  - HTN, thyroid issues, hyperlipidemia, migraines, allergies, tobacco use, current medications, alcohol, drug use, etc.
- Mental/psychological issues
  - Depression, anxiety, bipolar, alcohol/drug abuse, etc.
  - Depression scale/measurement (EPDS, PHQ-9, etc.)
  - Intimate partner abuse/violence
- Reproductive health issues
  - Previous Pap history, mammograms, UTI history
- Sexual health issues

Depression Scales (Examples)

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time — This would mean: "I have felt happy most of the time" during the past week.
- ☐ No, not very often — Please complete the other questions in the same way.
- ☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all
2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

Reproductive Health

- Pregnancy history
  - Gravida, para, (term, preterm, spontaneous/elective abortions, living children); G4P2113
  - Desire more children?
- Contraception use
  - Previous, current, desired
- Chromosome disorders (family history)
  - Down Syndrome, Cleft palate/lip, Trisomy disorders, etc.
- Infertility treatments/workup
  - Clomid, IUI, IVF
- Gynecological issues/previous surgeries
  - Vaginal, cervical, uterine, ovarian, tubal surgeries; abnormal uterine bleeding, etc.

Contraceptive Guide

- https://www.cdc.gov/reproductivehealth/contraception/pdf/summary-chart-us-medical-eligibility-criteria_508tagged.pdf

Summary Chart of U.S. Medical Eligibility Criteria for Contraceptive Use

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Age		Menarche to <20 yrs: 2		Menarche to <20 yrs: 2		Menarche to <18 yrs: 1		Menarche to <18 yrs: 2		Menarche to <18 yrs: 1		Menarche to <40 yrs: 1	
		≥20 yrs: 1		≥20 yrs: 1		18-45 yrs: 1		18-45 yrs: 1		18-45 yrs: 1		≥40 yrs: 2	
						>45 yrs: 1		>45 yrs: 2		>45 yrs: 1			
Anatomical abnormalities	a) Distorted uterine cavity	4		4									
	b) Other abnormalities	2		2									
Anemias	a) Thalassemia	2		1		1		1		1		1	
	b) Sickle cell disease‡	2		1		1		1		1		2	
	c) Iron-deficiency anemia	2		1		1		1		1		1	
Benign ovarian tumors	*(including cysts)*	1		1		1		1		1		1	
Breast disease	a) Undiagnosed mass	1		2		2*		2*		2*		2*	
	b) Benign breast disease	1		1		1		1		1		1	
	c) Family history of cancer	1		1		1		1		1		1	
	d) Breast cancer‡												
	i) Current	1		4		4		4		4		4	
	ii) Past and no evidence of current disease for 5 years	1		3		3		3		3		3	
Breastfeeding	a) <21 days postpartum					2*		2*		2*		4*	
	b) 21 to <30 days postpartum												
	i) With other risk factors for VTE					2*		2*		2*		3*	
	ii) Without other risk factors for VTE					2*		2*		2*		3*	
	c) 30-42 days postpartum												
	i) With other risk factors for VTE					1*		1*		1*		3*	
	ii) Without other risk factors for VTE					1*		1*		1*		2*	
	d) >42 days postpartum					1*		1*		1*		2*	
Cervical cancer	Awaiting treatment	4	2	4	2	2		2		1		2	
Cervical ectropion		1		1		1		1		1		1	
Cervical intraepithelial neoplasia		1		2		2		2		1		2	
Cirrhosis	a) Mild *(compensated)*	1		1		1		1		1		1	
	b) Severe‡ *(decompensated)*	1		3		3		3		3		4	
Cystic fibrosis‡		1*		1*		1*		2*		1*		1*	
Deep venous thrombosis (DVT)/Pulmonary embolism (PE)	a) History of DVT/PE, not receiving anticoagulant therapy												
	i) Higher risk for recurrent DVT/PE	1		2		2		2		2		4	
	ii) Lower risk for recurrent DVT/PE	1		2		2		2		2		3	
	b) Acute DVT/PE	2		2		2		2		2		4	
	c) DVT/PE and established anticoagulant therapy for at least 3 months												
	i) Higher risk for recurrent DVT/PE	2		2		2		2		2		4*	
	ii) Lower risk for recurrent DVT/PE	2		2		2		2		2		3*	
	d) Family history *(first-degree relatives)*	1		1		1		1		1		2	
	e) Major surgery												
	i) With prolonged immobilization	1		2		2		2		2		4	
	ii) Without prolonged immobilization	1		1		1		1		1		2	
	f) Minor surgery without immobilization	1		1		1		1		1		1	
Depressive disorders		1*		1*		1*		1*		1*		1*	

Condition	Sub-Condition	Cu-IUD I	Cu-IUD C	LNG-IUD I	LNG-IUD C	Implant I	Implant C	DMPA I	DMPA C	POP I	POP C	CHC I	CHC C
Diabetes	a) History of gestational disease	1		1		1		1		1		1	
	b) Nonvascular disease												
	i) Non-insulin dependent	1		2		2		2		2		2	
	ii) Insulin dependent	1		2		2		2		2		2	
	c) Nephropathy/retinopathy/neuropathy‡	1		2		2		3		2		3/4*	
	d) Other vascular disease or diabetes of >20 years' duration‡	1		2		2		3		2		3/4*	
Dysmenorrhea	Severe	2		1		1		1		1		1	
Endometrial cancer‡		4	2	4	2	1		1		1		1	
Endometrial hyperplasia		1		1		1		1		1		1	
Endometriosis		2		1		1		1		1		1	
Epilepsy†	*(see also Drug Interactions)*	1		1		1*		1*		1*		1*	
Gallbladder disease	a) Symptomatic												
	i) Treated by cholecystectomy	1		2		2		2		2		2	
	ii) Medically treated	1		2		2		2		2		3	
	iii) Current	1		2		2		2		2		3	
	b) Asymptomatic	1		2		2		2		2		2	
Gestational trophoblastic disease‡	a) Suspected GTD (immediate postevacuation)												
	i) Uterine size first trimester	1*		1*		1*		1*		1*		1*	
	ii) Uterine size second trimester	2*		2*		1*		1*		1*		1*	
	b) Confirmed GTD												
	i) Undetectable/non-pregnant ß-hCG levels	1*	1*	1*	1*	1*		1*		1*		1*	
	ii) Decreasing ß-hCG levels	2*	1*	2*	1*	1*		1*		1*		1*	
	iii) Persistently elevated ß-hCG levels or malignant disease, with no evidence or suspicion of intrauterine disease	2*	1*	2*	1*	1*		1*		1*		1*	
	iv) Persistently elevated ß-hCG levels or malignant disease, with evidence or suspicion of intrauterine disease	4*	2*	4*	2*	1*		1*		1*		1*	
Headaches	a) Nonmigraine (mild or severe)	1		1		1		1		1		1*	
	b) Migraine												
	i) Without aura (includes menstrual migraine)	1		1		1		1		1		2*	
	ii) With aura	1		1		1		1		1		4*	
History of bariatric surgery‡	a) Restrictive procedures	1		1		1		1		1		1	
	b) Malabsorptive procedures	1		1		1		1		3		COCs: 3	
												P/R: 1	
History of cholestasis	a) Pregnancy related	1		1		1		1		1		2	
	b) Past COC related	1		2		2		2		2		3	
History of high blood pressure during pregnancy		1		1		1		1		1		2	
History of Pelvic surgery		1		1		1		1		1		1	
HIV	a) High risk for HIV	2	2	2	2	1		1*		1		1	
	b) HIV infection					1*		1*		1*		1*	
	i) Clinically well receiving ARV therapy	1	1	1	1	If on treatment, see Drug Interactions							
	ii) Not clinically well or not receiving ARV therapy‡	2	1	2	1	If on treatment, see Drug Interactions							

Key:

1 No restriction (method can be used)	3 Theoretical or proven risks usually outweigh the advantages
2 Advantages generally outweigh theoretical or proven risks	4 Unacceptable health risk (method not to be used)

Abbreviations: C=continuation of contraceptive method; CHC=combined hormonal contraception (pill, patch, and ring); COC=combined oral contraceptive; Cu-IUD=copper-containing intrauterine device; DMPA = depot medroxyprogesterone acetate; I=initiation of contraceptive method; LNG-IUD=levonorgestrel-releasing intrauterine device; NA=not applicable; POP=progestin-only pill; P/R=patch/ring ‡ Condition that exposes a woman to increased risk as a result of pregnancy. *Please see the complete guidance for a clarification to this classification: www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm.

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		I	C	I	C	I	C	I	C	I	C	I	C
Hypertension	a) Adequately controlled hypertension	1*		1*		1*		2*		1*		3*	
	b) Elevated blood pressure levels (*properly taken measurements*)												
	i) Systolic 140-159 or diastolic 90-99	1*		1*		1*		2*		1*		3*	
	ii) Systolic ≥160 or diastolic ≥100[†]	1*		2*		2*		3*		2*		4*	
	c) Vascular disease	1*		2*		2*		3*		2*		4*	
Inflammatory bowel disease	(*Ulcerative colitis, Crohn's disease*)	1		1		1		2		2		2/3*	
Ischemic heart disease[‡]	Current and history of	1		2	3	2	3	3		2	3	4	
Known thrombogenic mutations[†]		1*		2*		2*		2*		2*		4*	
Liver tumors	a) Benign												
	i) Focal nodular hyperplasia	1		2		2		2		2		2	
	ii) Hepatocellular adenoma[‡]	1		3		3		3		3		4	
	b) Malignant[‡] (hepatoma)	1		3		3		3		3		4	
Malaria		1		1		1		1		1		1	
Multiple risk factors for atherosclerotic cardiovascular disease	(e.g., older age, smoking, diabetes, hypertension, low HDL, high LDL, or high triglyceride levels)	1		2		2*		3*		2*		3/4*	
Multiple sclerosis	a) With prolonged immobility	1		1		1		2		1		3	
	b) Without prolonged immobility	1		1		1		2		1		1	
Obesity	a) Body mass index (BMI) ≥30 kg/m²	1		1		1		1		1		2	
	b) Menarche to <18 years and BMI ≥ 30 kg/m²	1		1		1		2		1		2	
Ovarian cancer[‡]		1		1		1		1		1		1	
Parity	a) Nulliparous	2		2		1		1		1		1	
	b) Parous	1		1		1		1		1		1	
Past ectopic pregnancy		1		1		1		1		2		1	
Pelvic inflammatory disease	a) Past												
	i) With subsequent pregnancy	1	1	1	1	1		1		1		1	
	ii) Without subsequent pregnancy	2	2	2	2	1		1		1		1	
	b) Current	4	2*	4	2*	1		1		1		1	
Peripartum cardiomyopathy[‡]	a) Normal or mildly impaired cardiac function												
	i) <6 months	2		2		1		1		1		4	
	ii) ≥6 months	2		2		1		1		1		3	
	b) Moderately or severely impaired cardiac function	2		2		2		2		2		4	
Postabortion	a) First trimester	1*		1*		1*		1*		1*		1*	
	b) Second trimester	2*		2*		1*		1*		1*		1*	
	c) Immediate postseptic abortion	4		4		1*		1*		1*		1*	
Postpartum (*nonbreastfeeding women*)	a) <21 days					1		1		1		4	
	b) 21 days to 42 days												
	i) With other risk factors for VTE					1		1		1		3*	
	ii) Without other risk factors for VTE					1		1		1		2	
	c) >42 days					1		1		1		1	
Postpartum (*in breastfeeding or non-breastfeeding women, including cesarean delivery*)	a) <10 minutes after delivery of the placenta												
	i) Breastfeeding	1*		2*									
	ii) Nonbreastfeeding	1*		1*									
	b) 10 minutes after delivery of the placenta to <4 weeks	2*		2*									
	c) ≥4 weeks	1*		1*									
	d) Postpartum sepsis	4		4									

Condition	Sub-Condition	Cu-IUD		LNG-IUD		Implant		DMPA		POP		CHC	
		I	C	I	C	I	C	I	C	I	C	I	C
Pregnancy		4*		4*		NA*		NA*		NA*		NA*	
Rheumatoid arthritis	a) On immunosuppressive therapy	2	1	2	1	1		2/3*		1		2	
	b) Not on immunosuppressive therapy	1		1		1		2		1		2	
Schistosomiasis	a) Uncomplicated	1		1		1		1		1		1	
	b) Fibrosis of the liver[‡]	1		1		1		1		1		1	
Sexually transmitted diseases (STDs)	a) Current purulent cervicitis or chlamydial infection or gonococcal infection	4	2*	4	2*	1		1		1		1	
	b) Vaginitis (*including trichomonas vaginalis and bacterial vaginosis*)	2	2	2	2	1		1		1		1	
	c) Other factors relating to STDs	2*	2	2*	2	1		1		1		1	
Smoking	a) Age <35	1		1		1		1		1		2	
	b) Age ≥35, <15 cigarettes/day	1		1		1		1		1		3	
	c) Age ≥35, ≥15 cigarettes/day	1		1		1		1		1		4	
Solid organ transplantation[†]	a) Complicated	3	2	3	2	2		2		2		4	
	b) Uncomplicated	2		2		2		2		2		2*	
Stroke[‡]	History of cerebrovascular accident	1		2		2	3	3		2	3	4	
Superficial venous disorders	a) Varicose veins	1		1		1		1		1		1	
	b) Superficial venous thrombosis (acute or history)	1		1		1		1		1		3*	
Systemic lupus erythematosus[‡]	a) Positive (or unknown) antiphospholipid antibodies	1*	1*	3*		3*		3*	3*	3*		4*	
	b) Severe thrombocytopenia	3*	2*	2*		2*		3*	2*	2*		2*	
	c) Immunosuppressive therapy	2*	1*	2*		2*		2*	2*	2*		2*	
	d) None of the above	1*	1*	2*		2*		2*	2*	2*		2*	
Thyroid disorders	Simple goiter/ hyperthyroid/hypothyroid	1		1		1		1		1		1	
Tuberculosis[‡] (*see also Drug Interactions*)	a) Nonpelvic	1	1	1	1	1*		1*		1*		1*	
	b) Pelvic	4	3	4	3	1*		1*		1*		1*	
Unexplained vaginal bleeding	(suspicious for serious condition) before evaluation	4*	2*	4*	2*	3*		3*		2*		2*	
Uterine fibroids		2		2		1		1		1		1	
Valvular heart disease	a) Uncomplicated	1		1		1		1		1		2	
	b) Complicated[‡]	1		1		1		1		1		4	
Vaginal bleeding patterns	a) Irregular pattern without heavy bleeding	1		1	1	2		2		2		1	
	b) Heavy or prolonged bleeding	2*		1*	2*	2*		2*		2*		1*	
Viral hepatitis	a) Acute or flare	1		1		1		1		1		3/4*	2
	b) Carrier/Chronic	1		1		1		1		1		1	1
Drug Interactions													
Antiretroviral therapy All other ARV's are 1 or 2 for all methods.	Fosamprenavir (FPV)	1/2*	1*	1/2*	1*	2*		2*		2*		3*	
Anticonvulsant therapy	a) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	1		1		2*		1*		3*		3*	
	b) Lamotrigine	1		1		1		1		1		3*	
Antimicrobial therapy	a) Broad spectrum antibiotics	1		1		1		1		1		1	
	b) Antifungals	1		1		1		1		1		1	
	c) Antiparasitics	1		1		1		1		1		1	
	d) Rifampin or rifabutin therapy	1		1		2*		1*		3*		3*	
SSRIs		1		1		1		1		1		1	
St. John's wort		1		1		2		1		2		2	

Updated July 2016. This summary sheet only contains a subset of the recommendations from the U.S. MEC. For complete guidance, see: http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm. Most contraceptive methods do not protect against sexually transmitted diseases (STDs). Consistent and correct use of the male latex condom reduces the risk of STDs and HIV.

CS266008-A

Contraceptive Conversation Starter

Sexual Health (based on age)

- Sexual orientation
  - Heterosexual, homosexual, bisexual
- Sexual experiences
  - Dyspareunia, ability/inability to reach orgasm, etc.
- Sexual practices
  - Oral, anal, vaginal, self-stimulation (toys, masturbation)
- History of sexual abuse/rape
  - Type, current issues, impact on sexual health/exams

STI/STD Screening

- Behaviors that increase STI/STD risk
  - Multiple sex partners; new sex partners, etc.
- History of STI/STD
  - Review past hx of STD diagnosis; treatments; recurrence of infection
- Protection against STI/STD
  - Does the patient use barrier devices?
  - Does the patient engage in high risk behaviors?
  - Knowledge of what is out there – areas with higher rates of certain STDs.

Sexually Transmitted Diseases

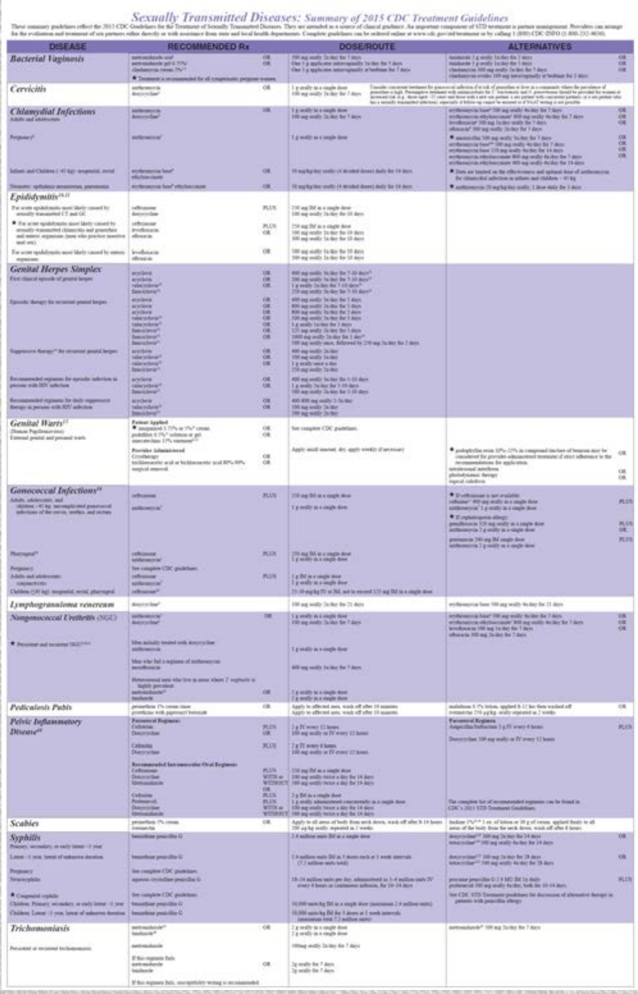
- According to the CDC: STDs in the US for 2015
  - Chlamydia: 1,526,658 reported cases, increase of 6% since 2014
  - Gonnorrhea: 395,216 reported cases, increase of 13% since 2014
  - Syphillis (primary and secondary): 23,872 reported cases, 19% increase since 2014
  - Syphillis (congenital): 487 reported cases, 6% increase since 2014
- Most GC/CT cases occur among 15-24 year olds
- Alaska (2015):
  - Ranked 1st among the 50 states for chlamydia
  - Ranked 8th for gonorrhea
  - Women were 2.2 times higher than men for chlamydial infections
  - Ranked 49th for syphillis

STD Screening Guidelines

- https://www.cdc.gov/std/tg2015/screening-recs-2015tg-revised2016.pdf
- Chlamydia:
  - Sexually active women under age 25; 25 and older at-risk; retest 3 months after treatment
  - All pregnant women under age 25; 25 and older at-risk women; retest in 3rd trimester for women under 25 or at risk; perform TOC 3-4 weeks after tx
- Gonorrhea:
  - Sexually active women under age 25; 25 and older at-risk; all pregnant women 25 and older at-risk; retest 3 months after treatment
- Syphilis:
  - All pregnant women at first prenatal visit and retest in early 3rd trimester and at delivery if at high risk

CDC Summary of STD Treatment Guidelines

- https://www.cdc.gov/std/tg2015/default.htm



Sexually Transmitted Diseases: Summary of 2015 CDC Treatment Guidelines

DISEASE	RECOMMENDED Rx	DOSE/ROUTE	ALTERNATIVES
Bacterial Vaginosis			
Cervicitis			
Chlamydial Infections			
Epididymitis			
Genital Herpes Simplex			
Genital Warts			
Gonococcal Infections			
Lymphogranuloma venereum			
Nongonococcal Urethritis (NGU)			
Pediculosis Pubis			
Pelvic Inflammatory Disease			
Scabies			
Syphilis			
Trichomoniasis			

Expedited Partner Therapy (EPT)

- Treating the sex partner(s) of a patient diagnosed with gonorrhea or chlamydia without first seeing/examining said partner(s)
  - Permissible in 41 states to include Alaska
    - "unprofessional conduct" includes the following… prescribing, dispensing, or furnishing a prescription medication to a person without first conducting a physical examination of that person…; this paragraph does not apply to prescriptions written or medications issued… for expedited partner therapy for sexually transmitted diseases. Alaska Admin. Code tit. 12 40,967(29)(B)
  - Potentially allowable in 7 states
  - Prohibited in 2 states (Kentucky and South Carolina)
- New treatment guidelines for gonorrhea (2012):
  - IM ceftriaxone (250mg) plus azithromycin (1g) slurry
  - EPT is not possible for IM injections in most cases
- As a clinician, you make the decision to utilize EPT
  - Education about treatment guidelines, medication allergies, medication warnings

Physical Exam

- Head-to-toe fashion:
  - Head
    - Dentition, hair growth/appearance (dry, brittle, etc.), peircings
  - Thyroid exam
    - Anterior and/or posterior approach
  - Body habitus
    - Note hair distribution, fat distribution (obesity, etc.), scars, tattoos, skin assessment, etc.
  - Breast exam
    - Inspect/palpate breasts and lymph nodes, piercings
  - Abdominal exam
    - Palpation, auscultation, piercings
  - Pelvic exam
    - Pap smear, bimanual exam, piercings

Cervical Cancer Screening Guidelines

- https://www.cdc.gov/cancer/cervical/pdf/guidelines.pdf

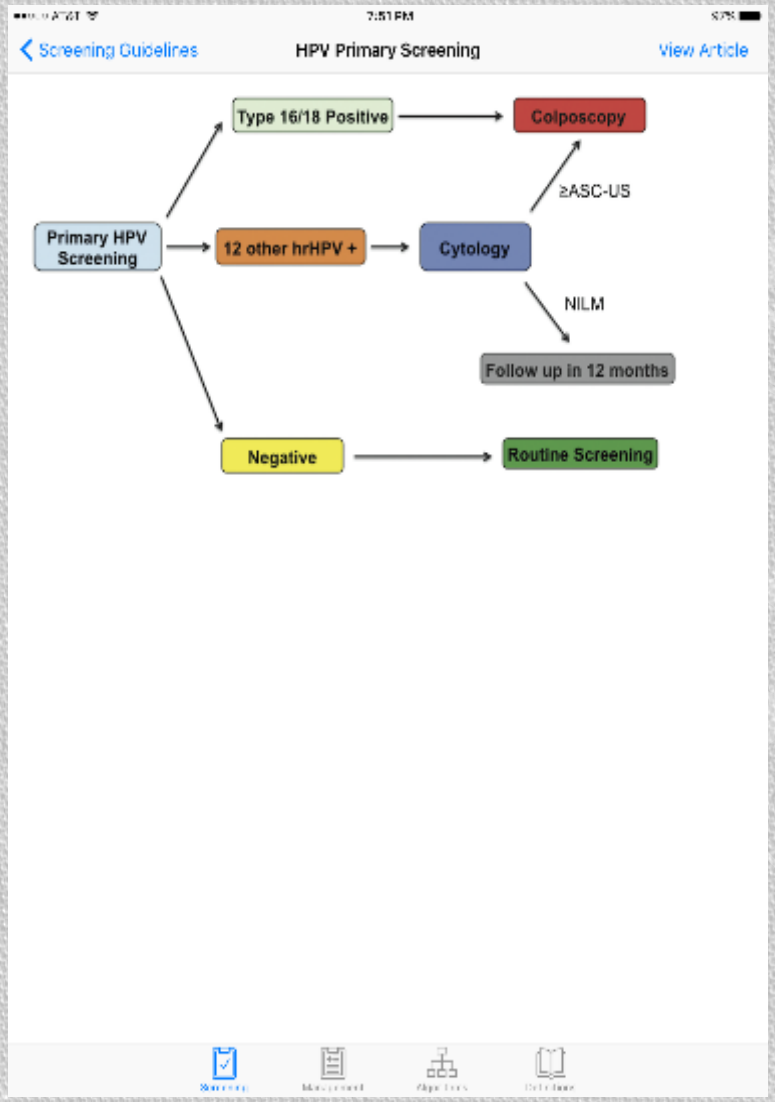
Cervical Cancer Screening Guidelines for Average-Risk Women[a]

	American Cancer Society (ACS), American Society for Colposcopy and Cervical Pathology (ASCCP), and American Society for Clinical Pathology (ASCP)[1] 2012	U.S. Preventive Services Task Force (USPSTF)[2] 2012	American College of Obstetricians and Gynecologists (ACOG)[3] 2012	Society of Gynecologic Oncology (SGO) and the American Society for Colposcopy and Cervical Pathology (ASCCP): Interim clinical guidance for primary hrHPV testing[4] 2015
When to start screening[b]	Age 21. Women aged <21 years should not be screened regardless of the age of sexual initiation or other risk factors.	Age 21. *(A recommendation)* Recommend against screening women aged <21 years *(D recommendation)*.	Age 21 regardless of the age of onset of sexual activity. Women aged <21 years should not be screened regardless of age at sexual initiation and other behavior-related risk factors *(Level A evidence)*.	Refer to major guidelines.
Statement about annual screening	Women of any age should not be screened annually by any screening method.	Individuals and clinicians can use the annual Pap test screening visit as an opportunity to discuss other health problems and preventive measures. Individuals, clinicians, and health systems should seek effective ways to facilitate the receipt of recommended preventive services at intervals that are beneficial to the patient. Efforts also should be made to ensure that individuals are able to seek care for additional health concerns as they present.	In women aged 30–65 years, annual cervical cancer screening should not be performed. *(Level A evidence)* Patients should be counseled that annual well-woman visits are recommended even if cervical cancer screening is not performed at each visit.	Not addressed.
Screening method and intervals				
Cytology (conventional or liquid based)[c] 21–29 years of age	Every 3 years.[d]	Every 3 years *(A recommendation)*.	Every 3 years *(Level A evidence)*.	Not addressed.
Cytology (conventional or liquid based)[c] 30–65 years of age	Every 3 years.[d]	Every 3 years *(A recommendation)*.	Every 3 years *(Level A evidence)*.	Not addressed.
HPV co-test (cytology + HPV test administered together) 21–29 years of age	HPV co-testing should not be used for women aged <30 years.	Recommend against HPV co-testing in women aged <30 years *(D recommendation)*.	HPV co-testing[e] should not be performed in women aged <30 years. *(Level A evidence)*	Not addressed.
HPV co-test (cytology + HPV test administered together) 30–65 years of age	Every 5 years; this is the preferred method.	For women who want to extend their screening interval, HPV co-testing every 5 years is an option *(A recommendation)*.	Every 5 years; this is the preferred method *(Level A evidence)*.	Not addressed.
Primary hrHPV testing[f] (as an alternative to cotesting or cytology alone)[g]	For women aged 30–65 years, screening by HPV testing alone is not recommended in most clinical settings.[h]	Recommend against screening for cervical cancer with HPV testing (alone or in combination with cytology) in women aged <30 years *(D recommendation)*.	Not addressed.	Every 3 years. Recommend against primary hrHPV screening in women aged <25 years of age.[i]
When to stop screening	Aged >65 years with adequate negative prior screening* and no history of CIN2 or higher within the last 20 years.[j] **Adequate negative prior screening results are defined as 3 consecutive negative cytology results or 2 consecutive negative co-test results within the previous 10 years, with the most recent test performed within the past 5 years.*	Aged >65 years with adequate screening history* and are not otherwise at high risk for cervical cancer[k] *(D recommendation)*.	Aged >65 years with adequate negative prior screening* results and no history of CIN 2 or higher[j] *(Level A evidence)*.	Not addressed.

Cervical Cancer Screening Guidelines

When to screen after age 65 years	Aged >65 years with a history of CIN2 CIN2, CIN3, or adenocarcinoma in situ, routine screening[k] should continue for at least 20 years.	Women aged >65 years who have never been screened, do not meet the criteria for adequate prior screening, or for whom the adequacy of prior screening cannot be accurately accessed or documented.[l] Routine screening[k] should continue for at least 20 years after spontaneous regression or appropriate management of a high-grade precancerous lesion, even if this extends screening past age 65 years. Certain considerations may support screening in women aged > 65 years who are otherwise considered high risk (such as women with a high-grade precancerous lesion or cervical cancer, women with in utero exposure to diethylstilbestrol, or women who are immunocompromised).	Women aged >65 years with a history of CIN2, CIN3, or AIS should continue routine age-based screening[k] for at least 20 years (Level B evidence).	Not addressed.
Screening post-hysterectomy	Women who have had a total hysterectomy (removal of the uterus and cervix) should stop screening.[m] Women who have had a supra-cervical hysterectomy (cervix intact) should continue screening according to guidelines.	Recommend against screening in women who have had a hysterectomy (removal of the cervix)[n] *(D recommendation).*	Women who have had a hysterectomy (removal of the cervix) should stop screening and not restart for any reason[n,o] *(Level A evidence).*	Not addressed.
The need for a bimanual pelvic exam	Not addressed in 2012 guidelines but was addressed in 2002 ACS guidelines.[p]	Addressed in USPSTF ovarian cancer screening recommendations (draft).[q]	Addressed in 2012 well-woman visit recommendations.[r] **Aged <21 years**, no evidence supports the routine internal examination of the healthy, asymptomatic patient. An "external-only" genital examination is acceptable. **Aged ≥21 years**, no evidence supports or refutes the annual pelvic examination or speculum and bimanual examination. The decision whether or not to perform a complete pelvic examination should be a shared decision after a discussion between the patient and her health care provider. Annual examination of the external genitalia should continue.[s]	Not addressed.
Screening among those immunized against HPV 16/18	Women at any age with a history of HPV vaccination should be screened according to the age specific recommendations for the general population.	The possibility that vaccination might reduce the need for screening with cytology alone or in combination with HPV testing is not established. Given these uncertainties, women who have been vaccinated should continue to be screened.	Women who have received the HPV vaccine should be screened according to the same guidelines as women who have not been vaccinated *(Level C evidence).*	Not addressed.

HPV Primary Screening



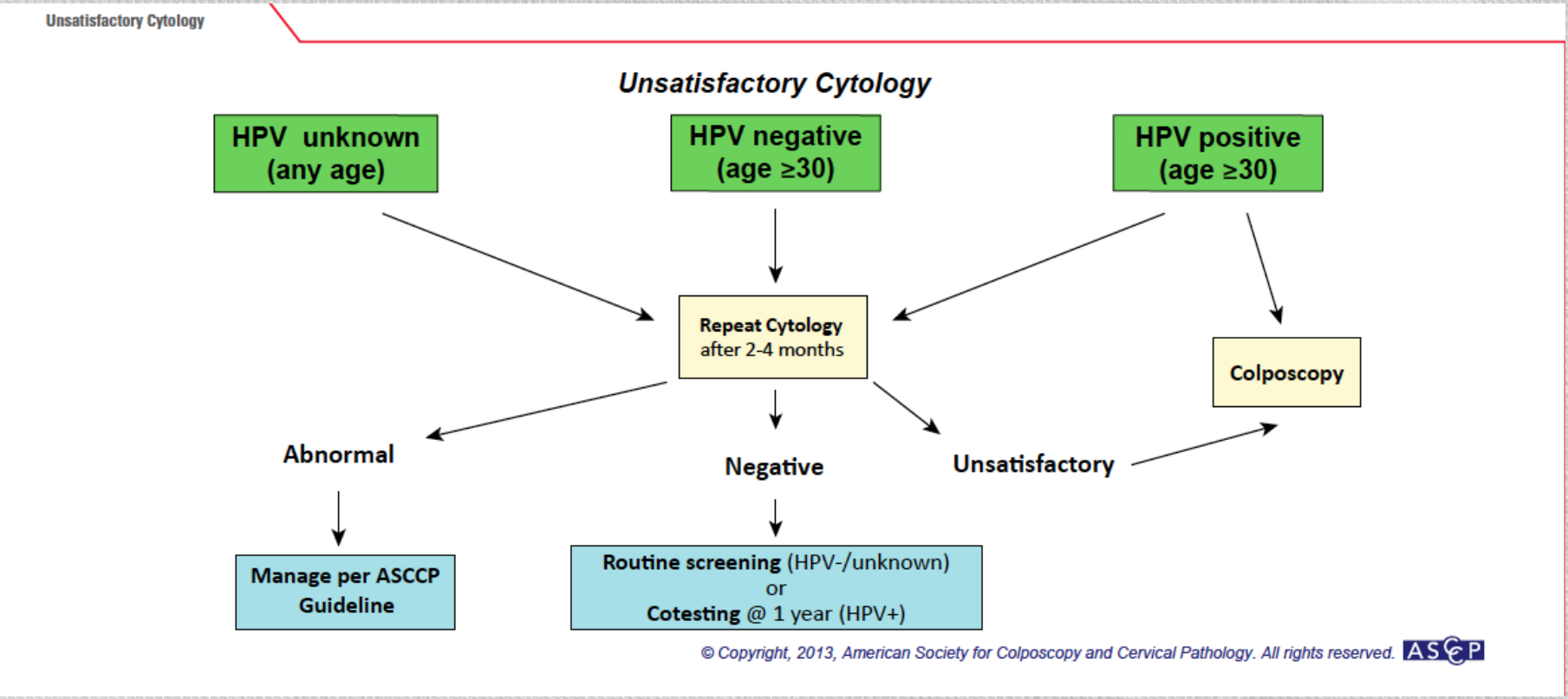
Pap Smears/Rationale

- 2001 – revised Bethesda system terminology for reporting cervical cytology results… standard approach for management. ASCCP developed management guidelines for unsatisfactory results
- 2006 – 2nd consensus conference aligned management of minor cytology abnormalities
- 2008 – ASCCP guidelines were updated but not validated by national consensus conference
- 2012 – National organizations published guidelines with longer screening intervals and later age to start screening. New evidence to guide decisions about abnormal findings
- 2012 – ASCCP conducted a consensus process to update management of abnormal co-testing results and cytology with specimen adequacy limitations, initial management of abnormal screening results, options for postcolposcopy management, management of women aged 21-24 years, and other issues.
- 2014 – FDA approved modified labeling of an hrHPV assay to include primary hrHPV screening for women 25 years and older

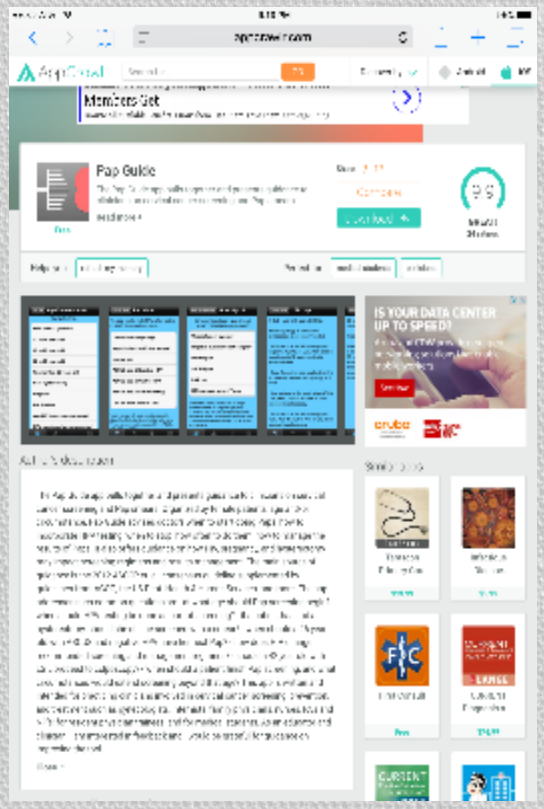
No Pap required!

- Do not screen in patients younger than 21 years of age
- Older than age 65:
  - IF adequate prior screening can be assessed accurately (3 consecutive negative cytology results or 2 consecutive negative HPV results within 10 years before screening cessation, with most recent test within the 5 years) and not otherwise at high risk for cervical cancer
- No cervix:
  - If the cervix was removed for benign reasons
- Recommendations DO NOT apply if:
  - Prior diagnosis of HSIL or cervical cancer
  - With in utero exposure to diethylstilbestrol (DES)
  - Immunocompromised women (HIV positive, organ transplant recipients, or chronic corticosteriod use)

What happens if the Pap results say ‘Unsatisfactory Cytology’?



Apps for Pap Smear Interpretation



Case Studies

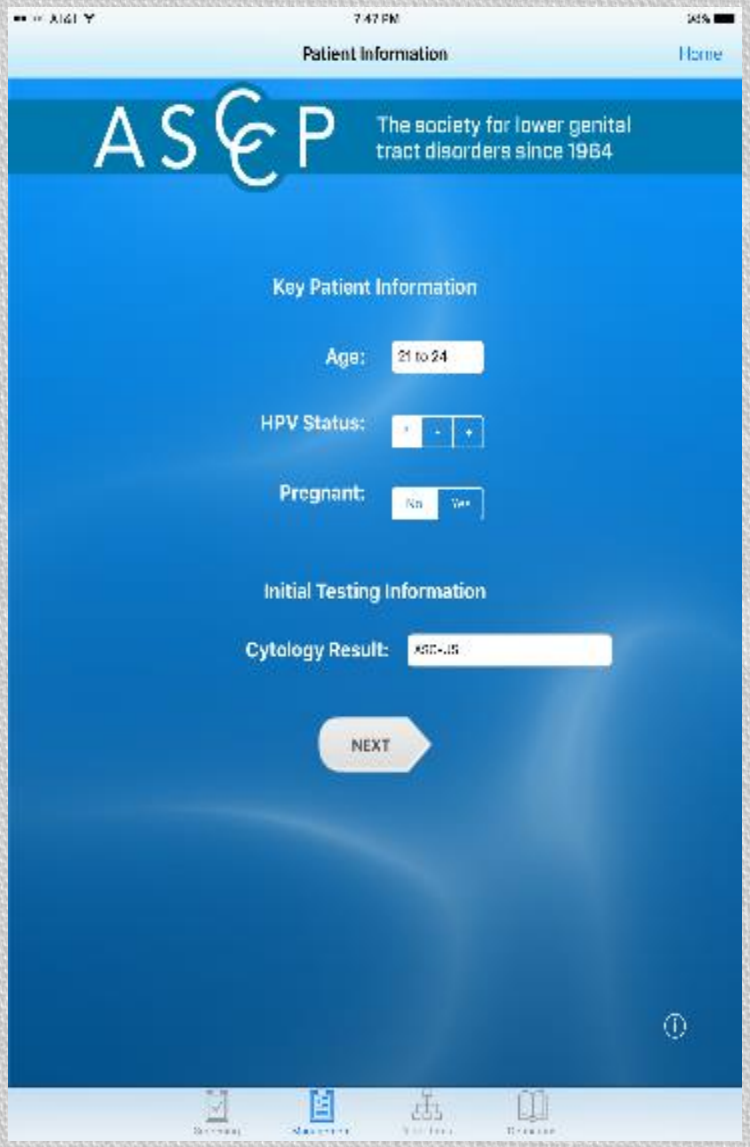
Case Study #1

- 22-year-old, G2P1011; 2016 SVD male 8lbs 5oz GHTN; EAB in 2011 at 8 weeks gestation; iron-deficiency anemia (daily iron supplementation); BMI 22; family hx of HTN (MGM); no other medical issues/history.
- States current monogamous relationship; positive chlamydia in 2015; states she is heterosexual
- No previous hx of Pap smear
- Desires contraception now but planning on trying to get pregnant in 1-2 years

Case Study #1

- Does this patient need a Pap smear?
  - Yes
- Would you screen for GC/CT?
  - Yes
- What contraceptives can she use? What would you recommend?
  - No restriction for Cu-IUD, LNG-IUD, Implant, DMPA, POP (1)
  - Advantage outweighs risk for CHC (2)
- What other counseling would you provide?
  - Preconception counseling; diet and exercise; adequate treatment of anemia; consider folic acid when actively trying to conceive.
- What is your next step if her Pap smear results ASCUS?

Navigating the Pap App:

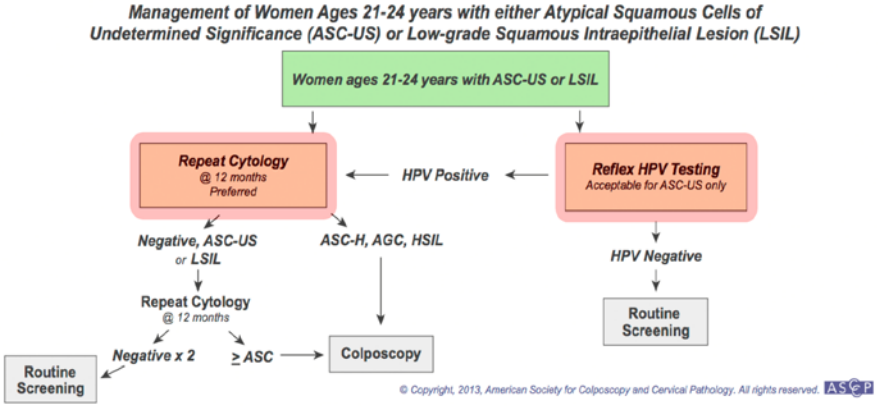


Repeat Cytology @ 12 months (Preferred) or Reflex HPV Testing (Acceptable)

Women with this result have a 5-year CIN3+ risk of 3.0%
READ MORE

5-YEAR RETURN	3-YEAR RETURN	1-YEAR RETURN	COLPOSCOPY
0.0%	0.0%	0.0%	0.0%

Guideline Algorithm



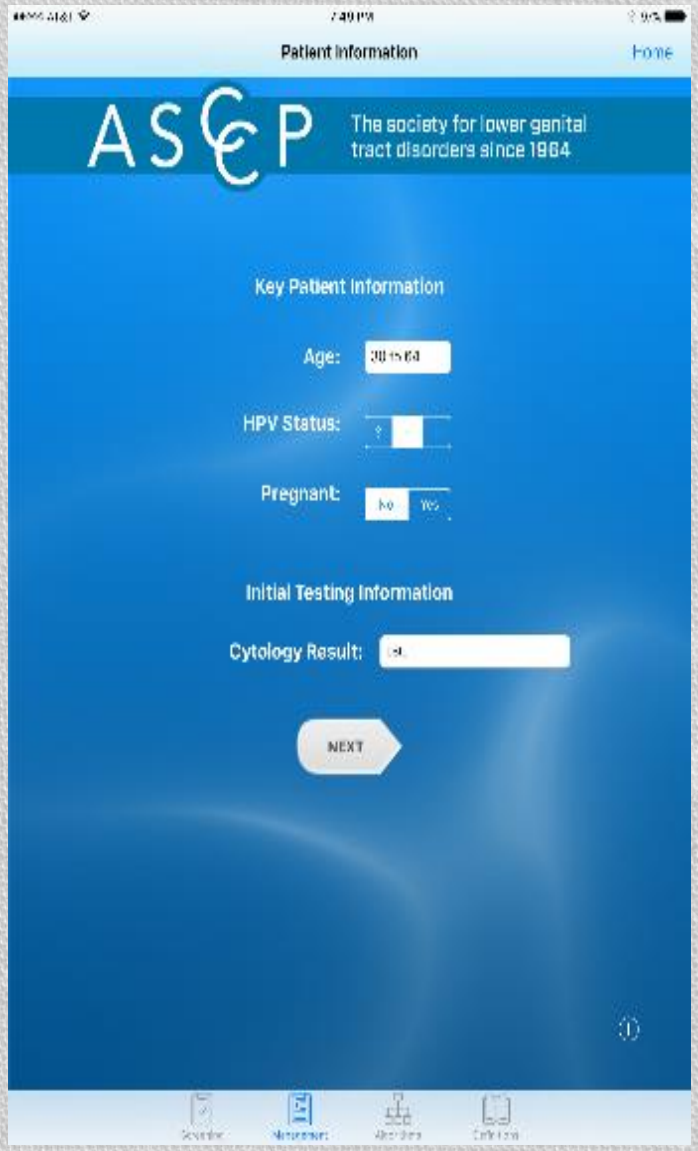
Next Steps

- Add 12 Month Cytology Followup Result
- Add Reflex HPV Testing Followup Result

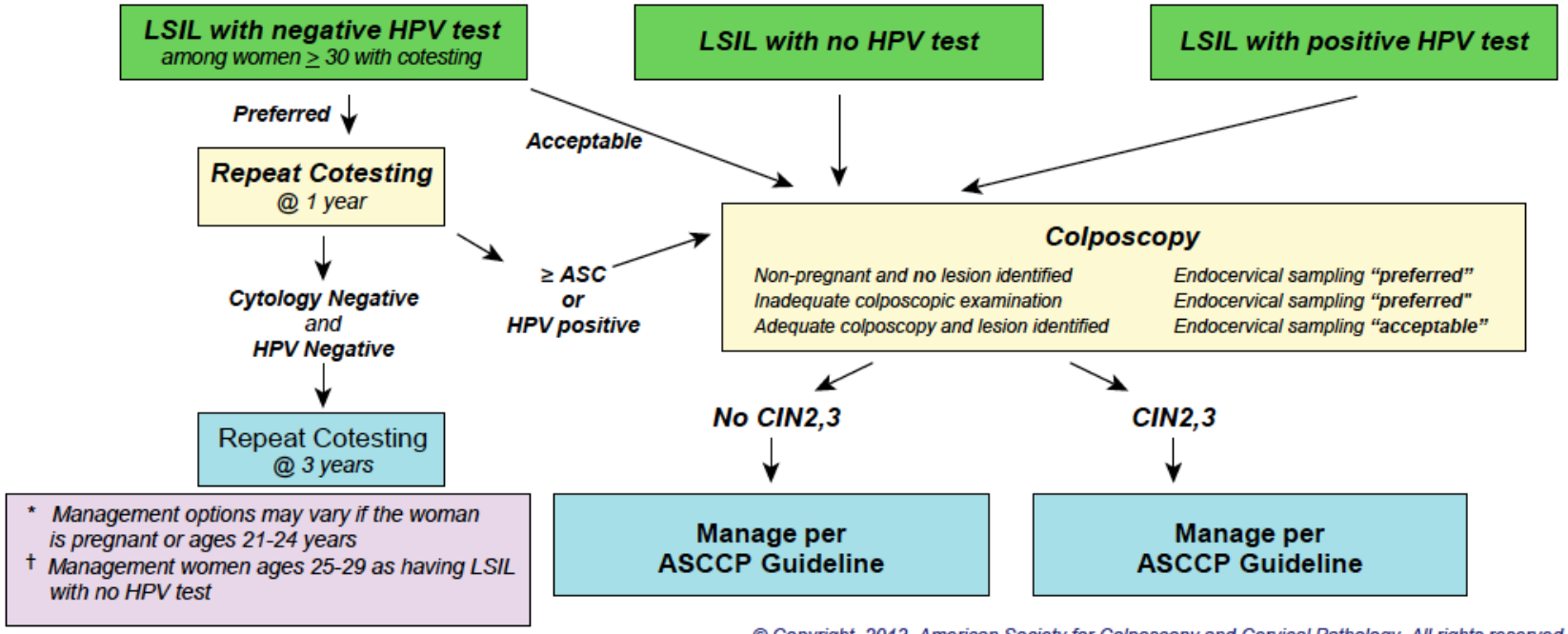
Case Study #2

- 33-year-old, G2P2002, SVDx2 (2007 & 2009) no complications; hypothyroidism (Synthroid 100mcg daily), CHTN (no meds), BMI 31; family hx of DM2 (mother, sister, maternal aunt, MGM).
- Recently divorced but has started dating again; states she is sexually active but not in a long-term relationship; states she is bisexual
- c/o vaginal discharge today with odor; has been present for "quite a while"; mild dysuria
- Last Pap 2016 (last year) resulted LSIL with negative HPV

Last Pap result recommendation:



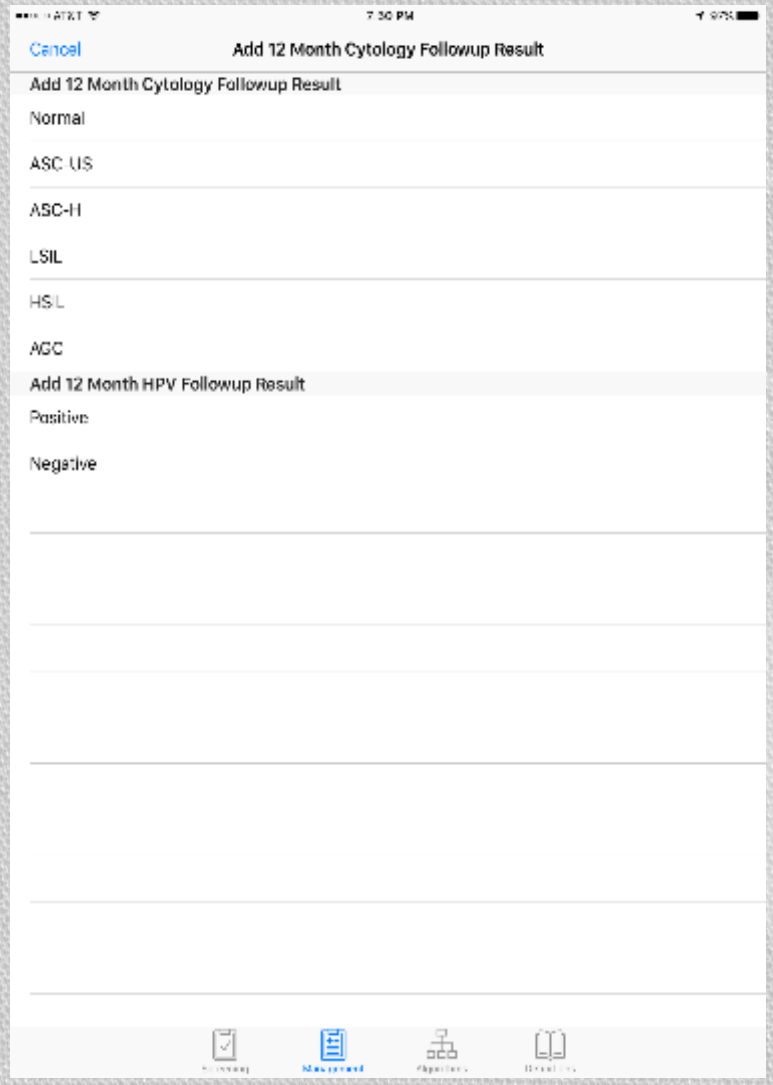
Management of Women with Low-grade Squamous Intraepithelial Lesions (LSIL)*†



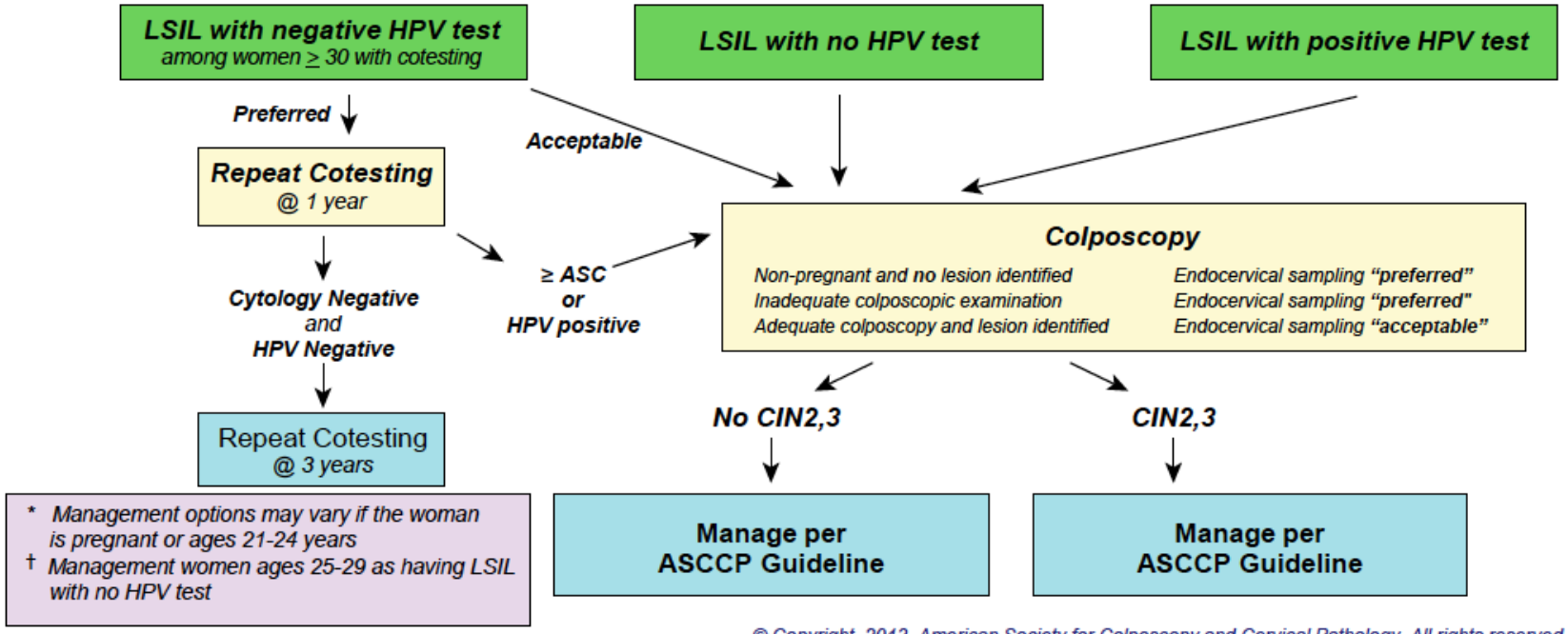
Case Study #2

- Does this patient need a Pap? Would you screen for HPV?
  - Yes and yes
- Would you screen for STDs? Which ones?
  - Yes; chlamydia, gonorrhea, trichomonas, could consider syphilis and HSV
  - Would also swab for candidiasis and bacterial vaginosis
- Would you counsel her about contraceptives? What options would you recommend for this patient?
  - Yes, if she does not desire children at this time; consider her medical hx of CHTN and obesity, do NOT recommend DMPA or CHC; If BPs are mild range, can consider IUDs, Implant or POP (1), if BPs are not well controlled, Cu-IUD
- What other counseling would you provide?
  - Safe sex practices, i.e. use of barrier devices to prevent STDs; not sharing sex toys and/or cleaning adequately after use;weight loss recommendation; diet and exercise recommendation; depression/mental health recommendation as indicated; diabetes screening; CHTN management; could consider thyroid screen if due

Case #2: new Pap results – LSIL, HPV+



Management of Women with Low-grade Squamous Intraepithelial Lesions (LSIL)*†



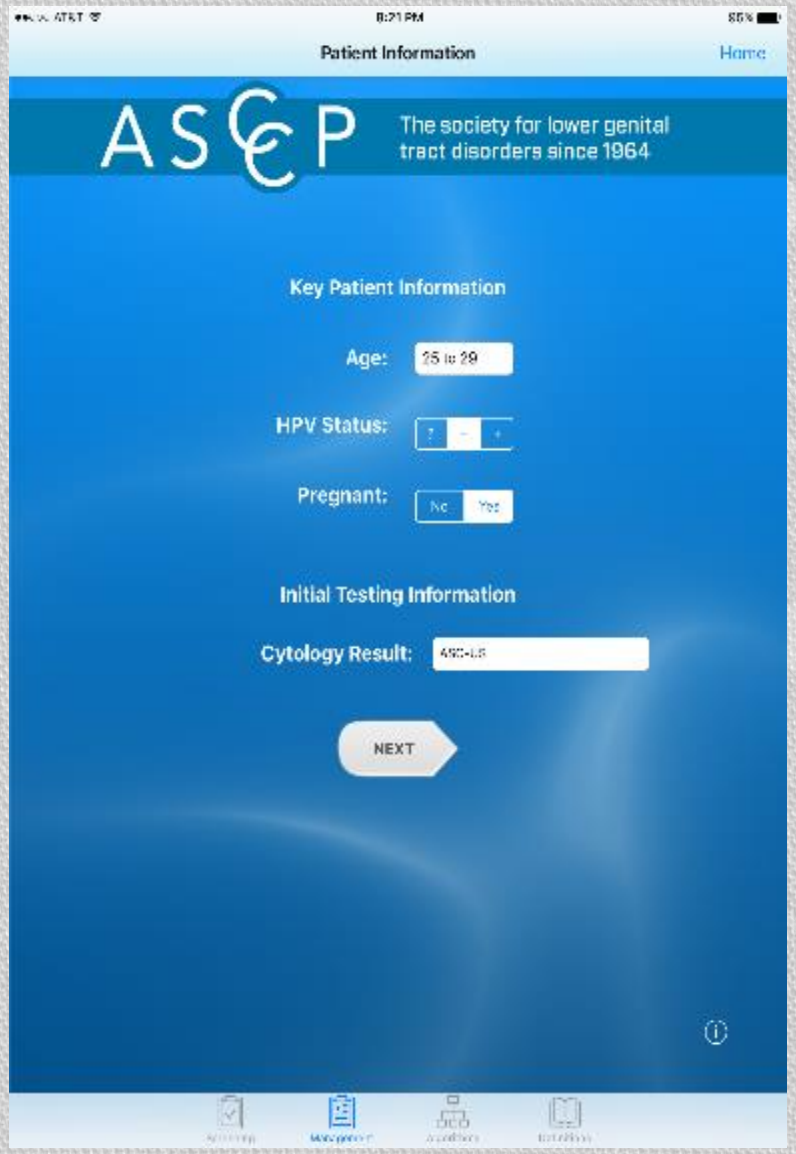
Case Study #3

- 26 year-old, G1P0000; no significant medical history; BMI 23; occupation RN; family hx of DM2 (mother, MGF)
- Currently in a long-term, same-sex relationship; pregnancy via IVF; IVF transfer date 2 Aug 2017 giving EDC of 20 Apr 2018; approximately 10 weeks gestation
- Last pap June 2014, normal; no hx of STDs
- Today c/o mild nausea and breast tenderness; denies vaginal discharge or bleeding; denies abdominal cramping; denies dysuria

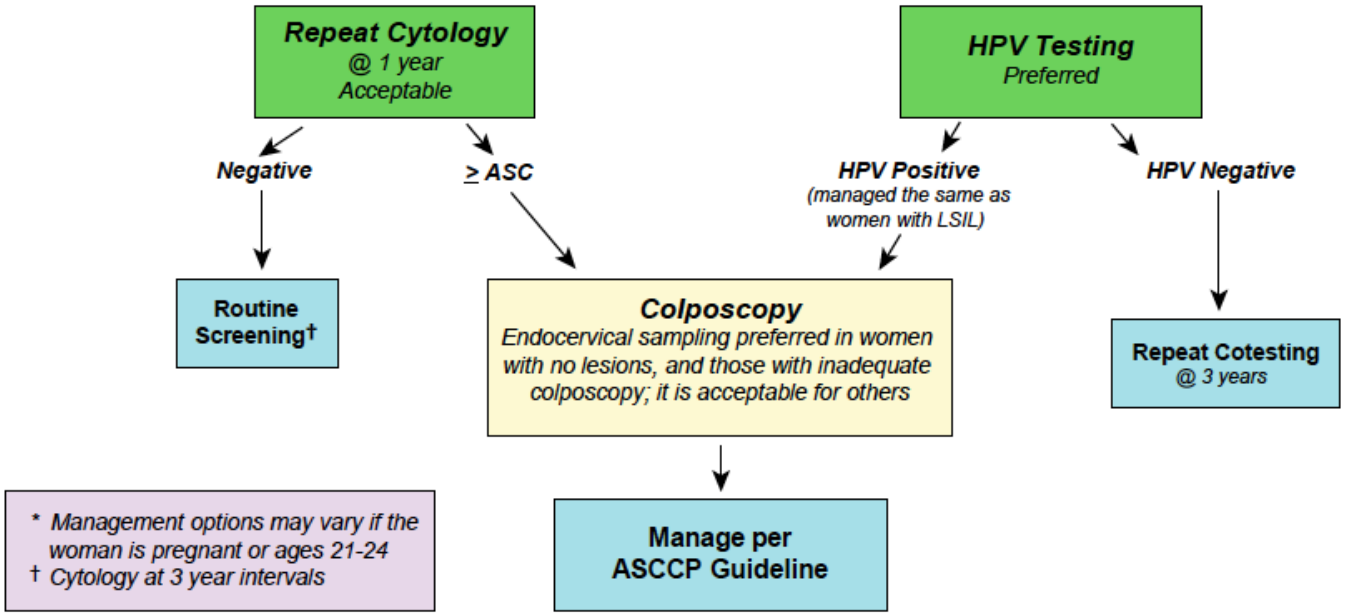
Case Study #3

- Does this patient need a Pap smear?
  - Yes
- Can you perform primary HPV screening on this patient?
  - Yes, she is a candidate
- Would you screen for STDs?
  - I screen all new OB patients for GC/CT, however, it's not required since she is 26 years old
- What other counseling would you provide?
  - Diet and exercise; universal precautions at work; lifting restrictions; recommend early diabetes screening due to family hx of first degree relative with DM2; refer for OB care if not provided in your clinic; include spouse in pregnancy appointments
- You choose to perform a Pap smear and the Pap results came back as ASCUS; what is your next step?

Case Study #3: Pap results



*Management of Women with Atypical Squamous Cells of Undetermined Significance (ASC-US) on Cytology**



Case Study #4

- 60 year-old, G6P6006; widowed x 8 years; s/p hysterectomy and bladder sling at age 48 for AUB and uterine prolapse, still has both ovaries; no significant medical hx; mild GERD symptoms, no medications; last mammogram normal; BMI 22
- Last Pap smear at age 50, normal, no HPV done; remote hx of abnormal Pap smear with normal colposcopy
- Recently (last 3 months) met a new guy at the bike shope when she had her mountain bike repaired; has started dating
- Today c/o vaginal dryness and itching with urge incontinence symptoms; would like to resume intercourse but experiences dyspareunia
- Physical exam: vaginal atrophy, pt unable to tolerate speculum or bimanual exam

Case Study #4

- Does this patient need a pap?
  - No
- Would you screen for STDs?
  - Probably not unless directed by physical exam
- What would you recommend for this patient?
  - Trial of topical Premarin cream (1/2 g applied externally at bedtime x 2 weeks, then MWF thereafter); may consider topical lidocaine for severe symptoms if patient opposed to Premarin use; recommend external masturbation or use of vibrator to increase blood flow to the area (use it or lose it); follow up in 4-6 weeks for effectiveness.
- What additional counseling would you provide?
  - STD counseling; yearly mammograms; diet and exercise

Summary

- Well woman exams don't have to be intimidating
- Find a Pap app that you like and that is easy to use
- Keep up to date on new recommendations for Pap smear schedules and STD treatment
- Be aware of what STDs are hot in your area
- Educate, educate, educate!

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Thanks!!