Date of visit: 03/23/26

Source of information: Self
Reliability: Reliable
Mode of transport: Self

Chief complaint: “I’ve had vaginal burning for the past year.”

HPI: L.R is a 68 year old female with past medical history of type II DM, CAD, and bilateral cataracts, G2P2002 and sp hysterectomy in 2025 who presents to the OBGYN clinic for her annual follow up. Pt complains of intermittent vaginal burning for the past year. She describes the sensation as a heavy, straining feeling in the pelvic region which she associates with lifting heavy bags frequently. Rated 6/10. The feeling is not constant and lasts for a couple hours before resolving spontaneously. She has been treated multiple times at outside clinics for presumed vulvovaginal candidiasis, which only minimally helps temporarily. She takes Tylenol with minimal relief of symptoms. Of note, pt admits to a habit of holding in her urine, particularly at night, because once she goes she has a difficult time falling back asleep. Pt also reports some vaginal dryness which she attributes to menopause. Pt denies vaginal discharge, pruritus, foul smell, bleeding, urinary urgency, frequency, dysuria, hematuria, or bowel/bladder incontinence. Denies pelvic trauma, recent infections, fever, chills, or unintentional weight loss.

Past Medical History
- Type II Diabetes Mellitus
- Coronary Artery Disease
- Cataracts of bilateral eyes

OBGYN History
G2P2002
NSVD x2
Currently postmenopausal; last menses at age 51
Not currently sexually active; last intercourse was 1 year ago with ex-boyfriend

Immunizations:
- COVID-19 vaccine in 2023
- Flu vaccine taken yearly; last in 2026
- Pneumococcal vaccine PCV 2 of 2 completed

Past Surgical History
- Hysterectomy due to fibroids in 2025 at QHC; no complications
- Cataract extraction with posterior chamber intraocular lens implantation OS in 2025 at QHC; no complications
- Peripheral iridotomy OU in 2024 at QHC; no complications

Medications
- Aspirin 81 mg EC tablet, one tablet by mouth daily
- Atorvastatin 10 mg tablet, one tablet by mouth daily at bedtime
- Metformin XR 500 mg 24 hour tablet, 2 tablets by mouth in the morning and 2 tablets in the evening
- Pioglitazone 45 mg tablet; one tablet by mouth daily
- Sodium chloride 5% ophthalmic solution, 1 drop into left eye daily

Allergies
No known drug, food, or environmental allergies.

Family History
- Mother is alive and well, age 88; pt denies any PMHx of mother
- Father is deceased at unknown age from “old age” per pt; pt denies any PMHx of father
- No siblings
- Daughter is alive and well, age 30, no PMHX
- Son is alive and well, age 32, no PMHx

Social History
Habits: denies smoking, drinking alcohol, or illicit drug use.
Diet: endorses healthy diet; admits to not drinking a lot of water.
Occupation: unemployed.
Exercise: does not exercise.
Travel: no recent travel.
Sleep habits: endorses healthy sleeping habits; about 7 hours per night.
Marital status/living situation: widowed; lives alone.
Sexual history: not currently sexually active; last intercourse was 1 year ago with ex-boyfriend; no hx of STDs

Screenings:
UTD with breast cancer screening via mammogram; last in 2025
UTD with colorectal cancer screening via colonoscopy; last in 2022
UTD with cervical cancer screening via pap smear; last in 2025
Retinopathy screening in 2026

ROS
General: denies weight loss, loss of appetite, fatigue, weakness, fever, chills, or night sweats
Skin: denies rash, itching, excessive sweating or dry skin
Genitourinary: denies urinary frequency or urgency, nocturia, dysuria, hematuria, incontinence, or flank pain
Gastrointestinal: denies nausea, vomiting, diarrhea, constipation, fecal incontinence, abdominal pain, or decreased appetite
Musculoskeletal: denies lower back pain, swelling, redness, deformity, or trauma
Endocrine: denies thyroid gland enlargement, heat or cold intolerance, changes in facial or body hair, change in weight or excessive hair growth
Pulmonary: denies cough, SOB, orthopnea, sputum, hemoptysis, or wheezing
Cardiovascular: denies chest pain, jaw pain, palpitations, or swelling of legs or feet
GYN: reports vaginal burning and dryness; denies bleeding, discharge, malodor, itchiness, or dyspareunia

Physical Exam
General: 68 year old female, well nourished, well developed and well groomed. Pt appears stated age and is in no acute distress.

Vital Signs:
Blood pressure: 110/70 mmHg
Respiratory rate: 15 breaths per minute, unlabored
Pulse: 88 BPM, regular rate and rhythm
Temperature: 97.8 F
SpO2: 98%
Height: 5 feet 2 inches
Weight: 160 pounds
BMI: 29.26

Skin: warm and moist, good turgor. Nonicteric, no lesions.
Pulm: symmetrical expansion with respiration. No intercostal retractions, or tenderness. Breath sounds equal bilaterally. No rules, wheezes, or rhonchi auscultated.
CV: regular rate and rhythm. S1 and S2 heard. No murmur, thrills, or clicks.
Abdomen: soft and non distended. No tenderness or guarding. No palpable masses or organomegaly. No inguinal hernia. No palpable lymphadenopathy.
Extremities/MSK: no obvious deformities, clubbing, cyanosis, or edema noted. No visible joint swelling or erythema. Normal ROM. Bilateral upper and lower pulses present.
Pelvic exam: no inguinal adenopathy. External genitalia without erythema, lesions, or masses. Vaginal mucosa pink. Cervix parous, pink, and without discharge. When asked to bear down, anterior vaginal wall +1 cm, posterior vaginal wall -2 cm, posterior cervix -5 cm.

Assessment

Pt is a 68 year old postmenopausal female with PMHx of type II DM, G2P2002 sp hysterectomy in 2025, who presents to the clinic for intermittent vaginal burning x 1 year. Pain is described as a heavy/straining sensation located in the pelvic region. Reports prior treatments for suspected candidiasis, as well as a habit of holding in her urine. She also reports mild dryness in the vaginal area secondary to menopause. Pt denies bleeding, discharge, malodor, or urinary/bowel incontinence. On exam, anterior vaginal wall is 1 cm below the hymen, indicating a mild prolapse of the anterior vaginal wall.

Differential Diagnoses:

1. Pelvic Organ Prolapse
    A. The patient's presentation and physical exam are most consistent with a pelvic organ prolapse, more specifically a vaginal vault prolapse. Her symptoms are classic for prolapse, including a pelvic heaviness and straining sensation, which she associates with lifting heavy bags. She has multiple risk factors for prolapse, including older age and postmenopausal state, multiparity, and constant heavy lifting (causing an increase in intra-abdominal pressure). Further, the pt is sp hysterectomy. When the uterus is removed, the vaginal vault loses its main support structures, such as the uretosacral ligaments. Finally, on physical exam, when asked to bear down, the anterior vaginal wall was 1 cm below the hymen, which indicates a pelvic organ prolapse.
2. Atrophic Vaginitis
    A. Patient is 68 years old and post menopausal, therefore has decreased estrogen which causes thinning of the vaginal epithelium, and decreased lubrication which causes increased fragility and irritation. Hallmark signs of atrophic vaginitis include vaginal burning and dryness, which the patient reports. Her chronic presentation (1 year) and absence of discharge, pruritus, and odor makes infection less likely. Her physical exam is more consistent with a prolapse, as her mucosa is pink and not clearly atrophic.
3. Pelvic Floor Dysfunction
    A. This should be considered given patient's history of multiparity, advanced age, and chronic increase in intra-abdominal pressure from frequent heavy lifting. All of these factors contribute to weakening and impaired coordination of the pelvic floor muscles. This would lead to symptoms such as pelvic pressure and straining sensation, which the patient reports. Additionally, pelvic floor dysfunction often coexists with pelvic organ prolapse, which is present on physical exam (and why pelvic floor dysfunction is less likely the primary diagnosis).
4. Recurrent Vulvovaginal Candidiasis
    A. Recurrent vulvovaginal candidiasis should be considered in this patient, given history of type II DM, which is a risk factor (as it increases glucose in the tissues and increases candida growth) and history of treatment for candidiasis multiple times in the past (but only provided minimal relief). Her chief complaint is vaginal burning, which can be a presenting symptom of candidiasis, but she lacks hallmark symptoms, such as pruritus, thick discharge, and malodor.

5. Chronic UTI
    A. Although least likely given lack of classic UTI symptoms such as dysuria, urgency or frequency, UTI should be ruled out in this patient especially given her history of type II DM and history of holding in her urine, which allows the bacteria more time to proliferate.

Plan/Workup

Labs/Imaging:

- Urinalysis to evaluate for asymptomatic bacteriuria given history of DM and habit of holding urine, and to help differentiate infectious vs noninfectious causes of symptoms.

Medications:

- Vaginal estrace for vaginal burning/dryness

Plan for most likely diagnosis of vaginal vault prolapse:

- Kegel exercises
- Will consider pessary if symptoms persist or worsen

Patient education:

Pt was counseled on managing diabetes via medication adherence and diet high in nutrients and low in fat and carbohydrates, emphasizing portion-control with vegetables, fruits, whole grains, and lean protein. She was advised to continue seeing her PCP for medical management of DM. She was also educated on the benefits of exercise, including daily walks for 20-30 minutes.

Pt was advised to increase her water intake and to avoid holding in her urine to prevent irritation/ infection. She was also counseled on Kegel exercises for her prolapse, as they strengthen the pelvic floor muscles. Such exercises include squeezing the muscles as if she was stopping her urine flow, holding for a few seconds, and then relaxing. She was advised to do these exercises as often as she can. A guide on Kegel exercises was attached to her MyChart, which she has access to. She was also advised to avoid heavy lifting too frequently, as this can worsen the prolapse. Pt expressed understanding on all patient education provided. She was advised to return to the clinic in 3 months, which she agreed to make an appointment for before leaving today.