- Negative ultrasound or a normal mammogram in a patient with a discrete breast mass does not rule out malignancy; approximately 10% to 20% of palpable breast cancers are not detected by mammography or ultrasonography.
    - A patient with a palpable, firm breast mass but negative imaging results should undergo palpation-guided core needle biopsy. Core needle biopsy provides excellent tissue sampling for pathology and, if malignant, for hormone receptor status.
- Transvaginal ultrasonography can have a role in evaluation of postmenopausal bleeding to assess for endometrial thickness, a sign of endometrial hyperplasia, but it is not useful in assess bleeding in premenopausal women because of significant variations in endometrial thickness due to hormonal fluctuation throughout the menstrual cycle.
    - It therefore is not used routinely for evaluating premenopausal bleeding, unless a structural uterine abnormality is suspected.
- Benign prostatic hypertrophy (BPH) is the most common cause of lower urinary tract symptoms (LUTS) in men. However, the persistence of symptoms after treatment in the absence of bladder outlet obstruction on urodynamic testing and presence of irritative symptoms points to overactive bladder (OAB) as the diagnosis.
- The most common cause of lower urinary tract symptoms (LUTS) in men is benign prostatic hypertrophy. To evaluate BPH, the American Urological Association (AUA) recommends clinicians take a history, conduct a physical examination, use the AUA Symptom Index (AUA-SI)/International Prostate Symptom Score (IPSS) to quantify symptoms, and do a UA. The AUA-SI assesses symptoms, including incomplete emptying, frequency, intermittency, urgency, weak stream, straining, and nocturia during the past month.
    - Blood work and imaging are not first line.

- Any abnormal vaginal bleeding occurring in peri- and postmenopausal women warrants evaluation to rule out malignancy, usually with endometrial biopsy.
    - Patients do not need to be entirely postmenopausal to have increased risk.
    - Women with prolonged anovulation are exposed to unopposed estrogen without the normal endometrial protective effect of progesterone. This increases the risk for endometrial hyperplasia and malignancy, all of which can also occur in the peri-menopausal time as well.
- For women with severe vasomotor symptoms and vulvovaginal atrophy in menopause, first line treatment is a combination of oral estradiol and progestin.
    - Topical vaginal estrogen can help genitourinary syndrome of menopause, characterized by vaginal symptoms, such as vaginal burning or irritation; sexual symptoms, such as dyspareunia or sexual dysfunction; or urinary symptoms, such as dysuria or recurrent urinary infections, but will not address vasomotor symptoms.