COMMON GYNECOLOGY COMPLAINTS: CLINICAL ASSESSMENT & MANAGEMENT IN THE PRIMARY CARE SETTING

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Objectives & Learning Outcomes

- Evaluate and apply clinical knowledge utilizing evidence-based research and screening guidelines within primary care for women by:
  - Increasing comfort level in the management of women in a primary care setting who present with complaints of either menopausal symptoms or menstrual issues.
  
  - Discussing recent changes to the pap smear screening guidelines.

  - Discussing recent changes to the breast screening guidelines.
Why this discussion?

Some health care providers working within primary care may experience:

◦ Uncertainty regarding the recent changes to the pap smear and breast exam screening guidelines.

◦ Hesitancy about when to prescribe hormones or alternative options for menopausal symptom management.

◦ Unease regarding options for management of common menstrual issues.

Presentation focal areas:

◦ Pap smear management: when to screen & management of abnormal findings.

◦ Breast management: when to screen & management of abnormal findings.

◦ Menopause symptoms: Hormonal versus non-hormonal therapy options for management.

◦ Menstrual issues: options for management.
Cervical Cancer Screening: Average Risk Follow up Plan for Normal Pap Results

START SCREENING

◦ AGES: 21-29
  ◦ Every 3 years pap test
    ◦ HPV testing should not be used in this age group unless it’s needed after an abnormal Pap test result.

◦ AGES: 20-65
  ◦ Every 3 years if pap testing alone (acceptable plan)
  ◦ Every 5 years if co-testing using pap test & HPV screening combined (preferred plan, regardless of HPV vaccine series completion).
    (ACOG, 2015; ACS, 2016)

STOP SCREENING

◦ AGE 65 OR OLDER:
  ◦ NO history of moderate or severe cervical dysplasia/cervical cancer
  ◦ AND Negative pap smears for the x 3 or x2 co-testing’s all within last 10 years.

◦ After Hysterectomy: (for non-cancer reason only)
  ◦ Surgery for non-cancerous reasons (i.e. uterine fibroids, menorrhagia or uterine prolapse).
    ◦ Rule only applies if absent cervix (if cervix remains intact- “supracervical hysterectomy” follow regular guidelines above)
Cervical Cancer Screening: Follow up Plan for Abnormal Pap Results

**AGES 21-29**

- **ASCUS**: (Atypical Squamous cells)
  - AGES 21-24:
    - Repeat pap testing in 12 months
  - AGES 25-29:
    - Preferred plan- reflex HPV Test
    - Acceptable plan- repeat pap test in 12 months
- **LSIL**: (LOW grade squamous)
  - AGES 21-24: Repeat pap testing in 12 months
  - AGES 25-29: Gynecology referral for colposcopy
- **ASC-HSIL (cannot rule out HSIL), HSIL AGC (atypical glandular cells) or Cancer in-situ:**
  - Gynecology referral for colposcopy

**AGES 30 & OLDER**

- **ASCUS**: (Atypical Squamous cells)
  - HPV NEGATIVE: Repeat co-testing in 3 years
  - HPV POSITIVE: Gynecology referral- needs colposcopy
- **LSIL** (LOW grade squamous)
  - HPV NEGATIVE:
    - Preferred plan- Repeat pap testing in 12 months
    - Acceptable plan- Gynecology referral for colposcopy
  - HPV POSITIVE: Gynecology referral for colposcopy
- **ASC-HSIL (cannot rule out HSIL), HSIL AGC (atypical glandular cells) or Cancer in-situ:**
  - Gynecology referral for colposcopy

(ACOG, 2015; ACS, 2016)
Breast Cancer Screening

- **Women ages 40 to 44** should have the choice to start annual breast cancer screening with mammograms (x-rays of the breast) if they wish to do so.
- **Women age 45 to 54** should get mammograms every year.
- **Women 55 and older** should switch to mammograms every 2 years, or can continue yearly screening.
  - Screening should continue as long as a woman is in good health and is expected to live 10 more years or longer.
- **All women** should be familiar with the known benefits, limitations, and potential harms linked to breast cancer screening.
  - They also should know how their breasts normally look and feel and report any breast changes to a health care provider right away.
- **Some women** – because of their family history, a genetic tendency, or certain other factors – should be screened with MRIs along with mammogram.

(American Cancer Society, 2016, para. 2)
Breast Cancer: Risk Factor Assessment

- Likelihood of malignancy increases with age.
- Women aged 55 years and older most common age group
- Woman’s lifetime risk of being diagnosed with breast cancer: 1 in 8.
- Second leading cause of cancer deaths in women.
- Cellular changes: Erratic cell growth & proliferation in breast tissue.
  (Beckman et al., 2013; Schuiling & Likis, 2013)

General Family History Risk Factors for Carrying a BRCA1 or BCRA2 Mutation

- Known BRCA1 or BRCA2 mutation
- Breast and ovarian cancer
- Early onset breast cancer
- Multiple breast primaries
- Male breast cancer
- Ashkenazi ancestry
Nipple Discharge: Characteristics & Symptoms

- Identify any precipitating factors:
  - Sexual stimulation
  - Symptoms of infection or abscess
  - Any medication use (certain antipsychotics-common)
  - Recent or Long-term (>1 year) breastfeeding history

- Ask: about characteristics or possible associated concerns:
  - Duration & color of nipple discharge?
  - Occur spontaneously versus only during manipulation?
  - Any other breast symptoms?
  - Any hypothyroidism symptoms?

- Perform comprehensive breast exam:
  - Skin changes
  - Breast masses
  - Tenderness (mastalgia): cyclic versus non-cyclic with menses?

- Nipple Discharge:
  - Usually benign; can be endocrine or cancer related.
    - Normal= clear or milky
    - Bloody= needs surgical evaluation
    - Daily staining inside of bra = likely galactorrhea, which requires evaluation of the pituitary gland, medication or thyroid induced.

(Beckman et al., 2013; Schuiling & Likis, 2013)
Types of Benign Breast Masses

- **Fibroadenomas**: usually are mobile & non-tender, smooth with round or oval shape.
  - Common in teens-20's.

- **Lipomas**: fatty tissue in origin, soft, mobile.

- **Fat necrosis**: Inflammation of breast tissue

- **Hamartomas**: usually are glandular & connective tissue in origin.

- **Galactoceles**: fat globules
  
  (Schuiling & Likis, 2013)

- **Differential diagnoses**:
  - **Fibrocystic changes**: usually are bilateral & tender; symptoms can increase with caffeine usage & fluctuating hormones.

- **Infection or abscess**
  - **Mastitis**: usually only unilateral requires antibiotics & recommend continue breastfeeding

- **Malignancy**
  - Most breast masses are benign; but malignancy must always be considered & ruled out when found.
Breast Cancer: Symptoms & Changes

*Symptoms may be similar to benign disorders

◦ Breast pain (Mastalgia that is typically non-cyclic to menses)
  ◦ Intermittent, sharp, radiating outward
  ◦ Stabbing, throbbing, burning

◦ Nipple discharge
  ◦ Serous or bloody, but also could be clear

◦ Breast mass: typically >2cms size
  ◦ Fixed/immobile
  ◦ Irregular shaped/poorly defined margins
  ◦ Non-Tender

  ◦ Breast cancer masses: typically feel like a fixed, irregular, non-tender mass that fades out into the surrounding tissue.

(Beckman et al., 2013; Schuiling & Likis, 2013)

Breast Cancer: Symptoms & Changes

- **Asymmetric changes**
  - Dimpling
    - dimpling of the skin over the mass
  - Altered nipple direction or retraction
    - caused by the mass pulling the tissue inward
  - Ipsilateral lymphadenopathy

- **Skin changes**
  - Peau d’ orange signs (Orange peel appearance)
    - changes in skin texture usually indicates inflammatory breast cancer is present
  - Pink or red skin rash- discoloration of the skin
  - Breast edema

(Beckman et al., 2013; Schuiling & Likis, 2013)

Photo retrieval from http://www.dermatlas.net/images/400/ACF1F1.JPG
Common Types of Malignant Breast Cancers

*Age: single largest factor majority occur >age 50; risk increases with age.

*Caucasian most common race.

- **Carcinoma in Situ**
  - Ductal carcinoma in situ (DCIS)
  - Lobular carcinoma in situ (LCIS)
  - Invasive Breast Cancer

- **Invasive ductal carcinoma**
  - 80% of all breast cancers
  - Invasive lobular carcinoma
  
  (Beckman et al., 2013; Schuiling & Likis, 2013)

- **Paget’s disease**
  - 3% of breast cancers
  - Eczema-like changes
  - Underlying DCIS or invasive carcinoma (50%) cause
  - May be cause of nipple discharge

- **Inflammatory Carcinoma**
  - 1-4% of all breast cancers
  - More common in pregnancy
  - Warmth, redness, & induration, peau d’orange signs
Breast Mass Finding: Management

◦ Any mass found: a provider should order both a mammogram and ultrasound- with likely simultaneous referral to Gyn or Breast Specialist.
  ◦ 2nd opinion with exam
  ◦ Biopsy consideration after all imaging is complete
  ◦ Management depends on type of mass present

◦ Special considerations when ordering radiology:
  ◦ Adolescents
  ◦ Pregnant and lactating women
  ◦ Older women

(Beckman et al., 2013; Schuiling & Likis, 2013)
Assessment of Menstrual Complaints

- Important detailed menstrual and contraception history for consideration
  - **Menses onset or milestone changes:** age start of menarche and/or menopause.
  - **Pattern flow & characteristics:** cycle length, duration, estimated amount of flow & when recent changes in the menses pattern or flow.
    - Any spotting in between menses, skipping menses, or clotting?
  - **Pain:** Dysmenorrhea, chronic pelvic pain, or PMS symptoms
  - **Contraceptive use:** type, length of time used, & any side effects.
  - **Complete medication & medical history:** asking about endocrine or psychiatric disorders.
  - **Exercise and dietary habits:** assess for extremes
    (Schuiling & Likis, 2013)
Laboratory & Diagnostic Testing: for Menstrual Complaint Management

**Laboratory Tests**

- **Amenorrhea or Metrorrhagia**
  - Pregnancy test
  - Thyroid-stimulating hormone (TSH)
  - Follicular Stimulating hormone (FSH >30)
  - Prolactin level
  - Progesterone level: anovulatory cycles

- **Menorrhagia: (bleeding in between)**
  - Wet prep & STI testing

- **Menorrhagia**: check for Anemia & Fibroids or bleeding disorders (Von Willebrand’s)
  - Complete blood count.
  - Coagulation studies.
  - Serum ferritin test.

**Diagnostic Imaging & Tests**

- **Transvaginal ultrasonography (TVS):**
  - Rule out uterine enlargement, masses & fibroids.
  - If abnormal ultrasound: (consider GYN referral) & may need to order:
    - Magnetic resonance imaging (MRI)
    - Computerized tomography (CT) scan

- **Refer to GYN for:**
  - Endometrial biopsy or Hysteroscopy.
  - Abnormal imaging results as suspected cause.
  - Bleeding disorders or Premature Ovarian Dysfunction (<age 40) suspected.
  - Any failed therapy attempted >3 month for menstrual or pelvic pain regulation.
  - Cervical polyps continuing to bleed.
Menstrual Disorder: Assessment

The etiologies of abnormal uterine bleeding (AUB) should be classified based on the PALM–COEIN system:

◦ Polyp: cervical
◦ Adenomyosis: abnormal uterine tissue growth
◦ Leiomyoma: uterine fibroids
◦ Malignancy and hyperplasia
◦ Coagulopathy: Von Willebrands

◦ Ovulatory dysfunction: PCOS, hypothyroidism, stress, pituitary and extremes of weight or diet
◦ Endometrial: due to predictable cyclical reasons with normal ovarian function & exclusion of other causes
◦ Iatrogenic: unscheduled BTB from IUD, anticoagulant usage or hormonal therapy.
◦ Not otherwise classified: potential uterine arteriovenous malformations & myometrial hypertrophy or etiologies not yet classified

(Munro, Critchley, & Fraser, 2011)
Abnormal Menstrual Management

1. Menorrhagia
   - Is patient anemic or volume depleated?
     - Yes
       - Consider hospital admission, D&C, and/or hysteroscopy.
     - No
   - Is patient pregnant?
     - Yes
       - R/O ectopic, partial, or completed Sab, or pregnancy complications.
     - No
   - Is patient over 36 years of age?
     - Yes
       - Do endometrial biopsy.
     - No
       - Abnormal
         - Consider D&C, hysteroscopy, or hysterectomy.
       - Normal
         - Do pelvic examination.
       - Vaginal or cervical problems
         - Treat as appropriate.
       - Masses
         - Do ultrasound
       - Normal
         - Empiric treatment for DUB.

Figure 2. Evaluation of menorrhagia and dysfunctional uterine bleeding.
Menstrual Disorder: Management

- **Combined Oral Contraceptive’s (COC’s):** for non-emergent bleeding regulation due to anovulation, menorrhagia or hormonal fluctuation.
  - Monophasics & Triphasics
    - Usage to regulate hormonal fluctuations & stabilize endometrial lining.
  - Cyclic progestin therapy:
    - Chronic anovulatory bleeding management & used in shorter courses to induce a menses when skipping >3 months.

- **Progestin therapy (continual):** can effectively decrease excessive menstrual bleeding.
  - Depo Provera
  - Mirena IUD (only FDA approved for menorrhagia management).

- **NSAIDS:** decreases prostaglandin levels = decreasing pain & bleeding.

*Unresponsive to therapy >3-6 months:* consider endometrial biopsy if has normal imaging and testing.

(Sweet, Schmidt-Dalton, Weiss, & Madsen, 2012)
Client Hormone Based Complaints

- **Excessive estrogen:**
  - Nausea
  - Bloating
  - High blood pressure
  - Headache
  - Breast fullness or tenderness
  - Swelling of the ankles

- **Lack of estrogen:**
  - Spotting
  - Early or mid-cycle bleeding

- **Excessive progestin:**
  - Increased appetite or weight gain
  - Tiredness
  - Acne
  - Hair loss
  - Depression
  - Vaginal yeast infections

- **Lack of progestin:**
  - Late breakthrough bleeding
  - No period at all
Menopausal Management

- **Systemic Hormone Therapy (HT):**
  - Should be given only in the lowest dose & the shortest period possible
  - To decrease risk of serious adverse events (i.e. thromboembolic disease & breast cancer).

- **Vasomotor symptoms:**
  - Best managed with systemic HT (estrogen & progestin combination) or estrogen (ET) alone or in combination (requires progestin if uterus still intact).
  - Non-hormonal Alternatives: such as SSRIs, SNRIs, gabapentin and clonidine have been shown to be effective.

- **Vaginal symptoms:** best managed with topical HT
  - Systemic HT is effective but topical HT is preferable due to less adverse effects.

(American Family Physician, 2014; Obstetrics & Gynecology, 2014)
Menopausal Management: According to the Research

- **50% women discontinuing HT**: experience vasomotor symptom recurrence, regardless of age or duration of treatment.
- **Discontinuation approach**: data insufficient to recommend one approach over another (i.e. abrupt stoppage versus tapering regimen).
- **Continuation choice on HT**: should be an individualized choice.
  - Regardless of a woman’s age based on symptoms.
  - However advisement of the risk-to-benefit ratio should be provided then well-documented in the chart along with plan for continuation.

(American Family Physician, 2014; Obstetrics & Gynecology, 2014)

- **Data DOES NOT support vasomotor symptom treatment efficacy using**:
  - Progestin-only medications
  - Testosterone
  - Compounded bioidentical hormones
  - Phytoestrogens
  - Herbal supplements
- **Data is LIMITED regarding use of lifestyle modifications to control symptoms**:
  - Layering clothing
  - Maintaining a lower ambient temperature
  - Drinking cool liquids
  - Avoiding alcohol & caffeine.
References


