



OB/GYN Review for the Primary Care Provider

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Mammograms

- ▶ Screening Recommendations
 - ▶ ACOG
 - ▶ Annually starting at age 40
 - ▶ United States Preventive Services Task Force
 - ▶ Biennially between the ages of 50 and 74
 - ▶ Grade B: The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.

Pap Smears

- ▶ Screening Recommendations
 - ▶ Ages 21-29
 - ▶ Pap smear only q3Y
 - ▶ Ages 30 – 65
 - ▶ Pap + HPV -> If both negative -> Rpt pap in 5Y
 - ▶ 65 and older
 - ▶ No further pap smears necessary (no h/o CIN 2 or higher)
 - ▶ s/p Total Hysterectomy
 - ▶ No further pap smears necessary (no h/o CIN 2 or higher)

Pap Smear Screening Recommendations

Table 1. Screening Methods for Cervical Cancer for the General Population: Joint Recommendations of the American Cancer Society, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology* ↔

Population	Recommended Screening Method	Comment
Women younger than 21 years	No screening	
Women aged 21–29 years	Cytology alone every 3 years	
Women aged 30–65 years	Human papillomavirus and cytology cotesting (preferred) every 5 years Cytology alone (acceptable) every 3 years	Screening by HPV testing alone is not recommended*
Women older than 65 years	No screening is necessary after adequate negative prior screening results	Women with a history of CIN 2, CIN 3, or adenocarcinoma in situ should continue routine age-based screening for a total of 20 years after spontaneous regression or appropriate management of CIN 2, CIN 3, or adenocarcinoma in situ
Women who underwent total hysterectomy	No screening is necessary	Applies to women without a cervix and without a history of CIN 2, CIN 3, adenocarcinoma in situ, or cancer in the past 20 years
Women vaccinated against HPV	Follow age-specific recommendations (same as unvaccinated women)	

Pelvic Exams

- ▶ Recommendations

- ▶ ACOG

- ▶ Discuss with the patient whether a pelvic examination is appropriate or indicated
 - ▶ Recognizes that the recommendation for Annual pelvic examination is based on expert opinion, and limitations of the internal pelvic examination for screening should be recognized
 - ▶ Recommends routine annual well-woman visits

- ▶ USPSTF

- ▶ Not enough evidence to determine the benefits or harms of performing screening pelvic exams in **asymptomatic**, non-pregnant adult women for 4 specific conditions: ovarian cancer, BV, HSV, and trichomoniasis

Ovarian Cancer

- ▶ Screening
 - ▶ **NONE**
 - ▶ Harms
 - ▶ False Positives -> Serious Harms ->
 - ▶ Unnecessary Major Surgery
 - ▶ Major Anxiety

BRCA

- ▶ Women with a personal history of both breast cancer and ovarian cancer
- ▶ Women with ovarian cancer and a close relative—defined as mother, sister, daughter, grandmother, granddaughter, aunt—with ovarian cancer, premenopausal breast cancer, or both
- ▶ Women of Ashkenazi Jewish descent with breast cancer who were diagnosed at age 40 or younger or who have ovarian cancer
- ▶ Women with breast cancer at 50 or younger and who have a close relative with ovarian cancer or male breast cancer at any age
- ▶ Women with a close relative with a known BRCA mutation

BRCA

- ▶ Genetic Counseling -> Risk greater than 20-25% ->
 - ▶ BRCA testing

BRCA+

- ▶ **Surveillance:** women may choose to undergo regular cancer screening in order to detect cancer at an early stage. This screening may need to begin at an early age. Screening tests for breast and ovarian cancer include clinical breast exam, mammography, breast magnetic resonance imaging (MRI), CA 125 testing, and transvaginal ultrasonography. It's important for women to be aware that there is still no clear evidence that screening for ovarian cancer reduces the risk of death from the disease.
- ▶ **Chemoprevention:** Hormonal therapy with tamoxifen has been shown to reduce the risk of breast cancer among women with a BRCA2 mutation. Tamoxifen may provide less of a breast cancer benefit among women with a BRCA1 mutation.
- ▶ **Prophylactic (preventive) surgery:** Bilateral prophylactic mastectomy (surgical removal of both breasts before cancer develops) greatly reduces the risk of breast cancer in women with a BRCA1 or BRCA2 mutation. Similarly, prophylactic removal of the ovaries and fallopian tubes reduces the risk of ovarian, fallopian tube, and peritoneal cancer. For women who are premenopausal, removal of the ovaries also reduces the risk of breast cancer.

ZIKA Virus



Zika Virus

- ▶ Microbiology
 - ▶ Arbovirus in the *Flaviviridae* family
- ▶ Transmission
 - ▶ *Aedes aegypti* species mosquito
 - ▶ Sexual intercourse
 - ▶ Blood transfusion

Zika Virus

- ▶ Clinical Presentation
 - ▶ 20% of infected individuals are symptomatic
 - ▶ Symptoms
 - ▶ Fever
 - ▶ Macular or Papular rash
 - ▶ Arthralgia
 - ▶ Conjunctivitis

Zika Virus

- ▶ Clinical Association
 - ▶ Increasing epidemiologic, clinical, laboratory, and pathologic evidence supports a link between Zika virus infection during pregnancy and adverse pregnancy and birth outcomes including
 - ▶ Microcephaly
 - ▶ Brain and Eye Abnormalities
 - ▶ IUGR
 - ▶ Fetal Death

Zika Virus

▶ Testing

- ▶ Assess all pregnant women for possible Zika virus exposure
 - ▶ If LESS than 2W from symptom onset **or** possible exposure ->
 - ▶ Zika virus rRT-PCR (serum **AND** urine)
 - ▶ If negative -> Zika virus IgM 2-12W after possible exposure
 - ▶ If MORE than 2W from symptom onset **or** possible exposure or in area with active Zika virus transmission in the first and second trimester ->
 - ▶ Zika virus IgM **and** Dengue virus IgM (serum) -> If positive ->
 - ▶ Reflex Zika virus rRT-PCR (serum and urine)
- ▶ Serologic tests may cross-react with antibodies against other flaviviruses, such as Dengue virus

Zika Virus

- ▶ Treatment
 - ▶ **NONE**
- ▶ Management
 - ▶ **Prevention!!! Prevention!!! Prevention!!! Prevention!!! Prevention!!!**

Zika Virus

▶ Management

▶ **Prevention!!! Prevention!!! Prevention!!! Prevention!!! Prevention!!!**

- ▶ Infected women -> wait 8W to conceive
- ▶ Infected men -> wait 6M to conceive
- ▶ Possible exposure -> wait 8W to conceive
 - ▶ Travel to or residence in the area of active Zika virus transmission or
 - ▶ Unprotected sex with a partner who has traveled to or lives in an area of active Zika virus transmission
 - ▶ **Routine testing is not currently recommended for women and men who are attempting to conceive who have had possible exposure but have not had clinical illness**

Sexual Health

▶ Female Sexual Dysfunction

- ▶ *Female sexual dysfunction encompasses a number of conditions that are characterized by one of the following symptoms:*
 - ▶ *loss of sexual desire* (sexual desire disorder)
 - ▶ *impaired arousal* (sexual arousal disorder)
 - ▶ *inability to achieve orgasm or* (orgasmic disorder)
 - ▶ *sexual pain* (sexual pain disorder)
- ▶ *A diagnosis of female sexual dysfunction is made when symptoms are sufficient to result in personal distress (marked distress or interpersonal difficulty)*

HSDD

- ▶ Hypoactive Sexual Desire Disorder

- ▶ Definition

- ▶ persistent or recurrent deficiency or absence of sexual desire or receptivity to sexual activity that causes **marked distress** or **interpersonal difficulty**

- ▶ Epidemiology

- ▶ Most common type of female sexual dysfunction
 - ▶ 5 – 14% of women in the United States
 - ▶ Peaks in women ages 40-60

HSDD

- ▶ Epidemiology
 - ▶ Premenopausal women younger than 40
 - ▶ situational circumstances, such as dysfunctional interpersonal relationships,
 - ▶ chronic disease
 - ▶ Depression
 - ▶ gynecologic disorders
 - ▶ use of certain medications
 - ▶ antidepressants, particularly selective serotonin reuptake inhibitors (**SSRIs**)
 - ▶ oral contraceptives (**OCPs**)
 - ▶ corticosteroids

HSDD

- ▶ Evaluation
 - ▶ History and Physical
 - ▶ Labs
 - ▶ Generally unnecessary unless Testosterone will be a consideration
 - ▶ Clinical diagnosis

Box 1. Brief Sexual Symptom Checklist for Women

Please answer the following questions about your overall sexual function:

1. Are you satisfied with your sexual function?

Yes No

If no, please continue.

2. How long have you been dissatisfied with your sexual function?

3a. The problem(s) with your sexual function is:

(mark one or more)

1 Problem with little or no interest in sex

2 Problem with decreased genital sensation (feeling)

3 Problem with decreased vaginal lubrication (dryness)

4 Problem reaching orgasm

4 [5] Problem with pain during sex

5 [6] Other:

3b. Which problem is most bothersome (circle)

1 2 3 4 5 [6]

[The problems were misnumbered in the source publication.—Ed.]

4. Would you like to talk about it with your doctor?

Yes No

Reprinted from Hatzichristou D, Rosen RC, Derogatis LR, Low WY, Meuleman EJ, Sadovsky R, et al. Recommendations for the clinical evaluation of men and women with sexual dysfunction. *J Sex Med* 2010;7:337–48. Review.

HSDD

- ▶ Treatment
 - ▶ Supportive management
 - ▶ Deliberate and specific effort to initiate sexual act
 - ▶ Subjectivity of normalcy
 - ▶ Pleasure oriented vs. Goal oriented endpoint
 - ▶ Therapy
 - ▶ Medical management
 - ▶ Addyi
 - ▶ Testosterone

HSDD

- ▶ Addyi
 - ▶ Flibanserin
 - ▶ only FDA approved treatment (8/18/2015) for the treatment of hypoactive sexual desire disorder in **premenopausal** women
 - ▶ Mechanism of Action
 - ▶ Serotonin agonist/antagonist
 - ▶ Post-synaptic 5HT1A receptor agonist and 5HT2A receptor antagonist
 - ▶ Involves regulation of several neurotransmitters that may influence sexual desire, balancing dopamine and norepinephrine sexual excitatory properties and lowering serotonin's effect of sexual satiety
 - ▶ the exact mechanism is not known

Addyi

- ▶ Dosage
 - ▶ 100mg PO qHS
- ▶ Pharmacotherapy
 - ▶ Reached peak levels within 45 – 60 minutes
 - ▶ Half life = 12 hours

Addyi

- ▶ Efficacy
 - ▶ Satisfying Sexual Event = SSE
 - ▶ Increased by 0.5 to 1 additional event over placebo
 - ▶ Baseline SSE = 2-3 per month
 - ▶ 33 – 50% increase in SSEs
 - ▶ Sexual desire scores improved in the treated group, but the improvements were not statistically significant

Addyi

- ▶ Side Effects
 - ▶ Dizziness
 - ▶ Nausea
 - ▶ Somnolence
 - ▶ Hypotension
 - ▶ Syncope

Addyi

- ▶ Contraindications

- ▶ ALCOHOL

- ▶ The alcohol interaction study to evaluate the effect of alcohol involved 23 men and 2 women required to drink the equivalent of a half of a bottle of wine within 10 minutes on a nearly empty stomach prior to taking the medication

- ▶ Hepatic dysfunction

- ▶ CYP3A4 inhibitors

- ▶ Fluconazole
 - ▶ Ketoconazole
 - ▶ PPIs

Addyi

- ▶ REMS
 - ▶ Risk Evaluation and Mitigation Strategy
 - ▶ Purpose
 - ▶ Severe hypotension and loss of consciousness
 - ▶ Components
 - ▶ Certify with the REMS program
 - ▶ Training + Questionnaire
 - ▶ Patient-Provider Agreement Form
 - ▶ Emphasizing the knowledge of the risks of consuming alcohol while taking the medication

HSDD

- ▶ Off Label

- ▶ Testosterone

- ▶ limited, prospective, randomized high-quality clinical trial data on testosterone for the management of HSDD. Consensus reports from the Endocrine Society and the North American Menopause Society have been cautionary

- ▶ Apparently effective

- ▶ Dose

- ▶ Compounded (0.5 – 2mg applied to inner thigh qDay)

- ▶ Side effects

- ▶ Hirsutism

- ▶ Acne

- ▶ Virilization

- ▶ CV Risk

- ▶ Breast Cancer

HSDD

- ▶ Testosterone

- ▶ ***The following conclusion is based on good and consistent scientific evidence (Level A):***

- ▶ Transdermal testosterone has been shown to be effective for the short-term treatment of hypoactive sexual desire disorder, with little evidence to support long-term use (longer than 6 months).

Resources

- ▶ ACOG
- ▶ CDC
- ▶ USPSTF

Thank You.

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