# PREVENTION AND SCREENING: WOMEN'S HEALTH GUIDELINES UPDATE

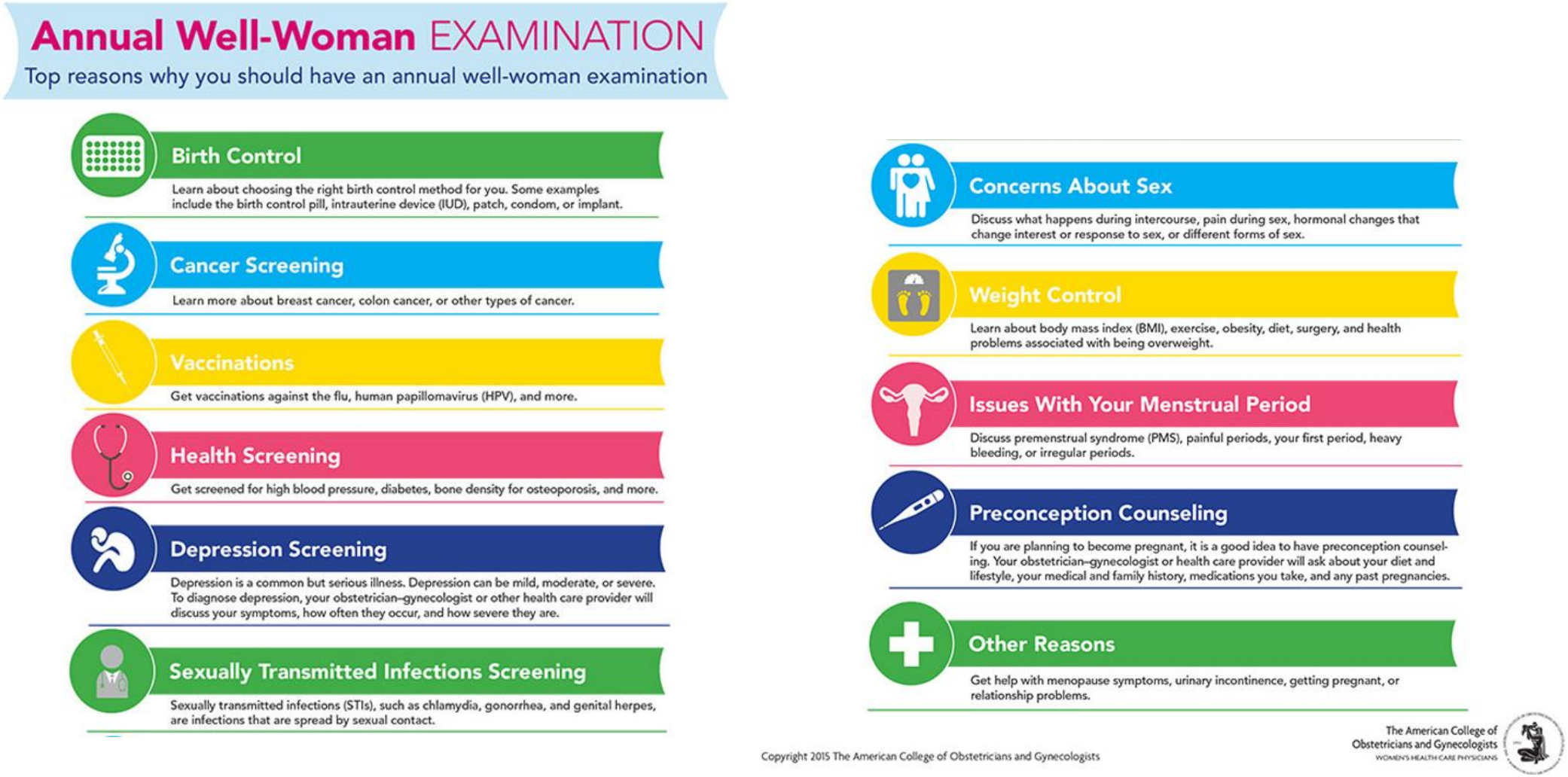
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UROLOGY, WOMEN'S HEALTH, SEXUAL MEDICINE

SKIN, BONES, HEARTS, AND PRIVATE PARTS 2021



# WELL WOMAN VISIT



# WELL WOMAN VISIT – WHAT SHOULD BE INCLUDED?

- History
  - Reason for visit
  - Heath status – medical, surgical, family
  - Dietary and nutrition assessment
  - Physical activity
  - Use of CAM
  - Tobacco, alcohol, recreational drug use
  - Abuse/neglect
  - Sexual practices
- Physical exam
  - Height
  - Weight
  - BMI
  - Waist circumference
  - BP and HR
- Evaluation and Counseling
  - Exercise and dietary assessment
- Psychosocial Evaluation
  - Interpersonal/family/friend relationship
- Cardiovascular Risk Factors
  - Family history
  - HTN, HLD, DM, Obesity
- Immunizations
  - DPT or Tdap booster
  - Varicella Vaccine
  - Influenza Vaccine

Should happen at least once a year.

# WELL WOMAN VISIT SPECIFICS

- Ages 13-18
  - School, safety, relationships, contraception
- Ages 19-39
  - Reproduction, perimenopause, increased risk factors, IPV
- Ages 40-64
  - Perimenopause, menopause, mammography, colonoscopy, osteoporosis
- Ages >65
  - Menopause and risk factors

# CERVICAL CANCER SCREENING

- New Guidelines April 2020
- Based on risk strategy – risk tables to guide practice
- Routine screening applies only to asymptomatic individuals who do not require surveillance for prior abnormal screening results
- New Guidelines
  - Recommendations (colposcopy and treatment vs surveillance) are based on risk for CIN 3+
    - Risk determined by prior history as well as screen results
    - Risk tables also address 'unknown history' scenario
  - Deferral of colposcopy: Low risk for CIN 3+ (risk defined by tables)
    - Repeat HPV testing or cotesting at 1 year
    - At the 1-year follow-up test, referral to colposcopy if still abnormal
  - Expansion of expedited treatment category (biopsy not needed prior to therapy), for example, in nonpregnant patients ≥25 years, expedited treatment is
    - Preferred: CIN 3+ risk is ≥60%
    - Preferred: HPV 16–positive HSIL cytology and never or rarely screened patients with HPV-positive HSIL regardless of HPV genotype
    - Acceptable: CIN 3+ risk is between 25% and 60%
    - Shared decision making is important in the context of "impact on pregnancy outcomes"
  - Excisional treatment
    - Preferred over ablation for HSIL (CIN 2 or CIN 3) in the US
    - Recommended for AIS
  - CIN 1
    - Observation is preferred vs treatment
    - Treatment acceptable with persistent CIN 1 results >2 years
  - Lower Anogenital Squamous Terminology (LAST)/World Health Organization (WHO) recommendations for reporting histologic HSIL
    - Include HSIL (CIN 2) and HSIL (CIN 3) (i.e., include CIN 2 and 3 qualifiers)
  - Reflex cytology
    - Should be performed on all positive HPV tests, regardless of genotype
    - If HPV 16 and 18 testing is positive but additional laboratory testing of the same sample is not feasible, proceed directly to colposcopy
  - Surveillance recommendations following histologic HSIL, CIN 2, CIN 3, or AIS
    - Continue surveillance with HPV testing or cotesting at 3-year intervals for at least 25 years (recommended)
    - >25 years is acceptable "for as long as the patient's life expectancy and ability to be screened are not significantly compromised by serious health issues"
  - HPV assays
    - The ASCCP consensus document states the following in reference to HPV tests

# CERVICAL CANCER SCREENING

| American Cancer Society | American College of Obstetricians and Gynecologists | U.S. Preventative Services Task Force |
|---|---|---|
| **Ages 25-64**<br>• Primary hrHPV testing only every 5 years<br><br>OR<br><br>• hrHPV and cytology every 5 years 25-64 years<br>• Cytology alone every 3 years<br><br>**Ages >65**<br>• Stop if normal testing and no history of CIN2+ | **Ages 21-29**<br>• Cytology alone every 3 years<br><br>**Ages 30-64**<br>• Preferred = CoTest (hrHPV and cytology) every 5 years<br>• Acceptable = Cytology alone every 3 years<br>• Can be considered = hrHPV screening alone no more frequently than every 3 years<br><br>**Ages >65**<br>• Stop if normal testing and no history of CIN2+ | **Ages 21-29**<br>• Cytology alone every 3 years<br><br>**Ages 30-64**<br>• Cytology alone every 3 years<br>• hrHPV testing only every 5 years<br>• CoTest (hrHPV and cytology) every 5 years<br><br>**Ages >65**<br>• Stop if normal testing and no history of CIN2+ |

# BREAST CANCER SCREENING

| American Cancer Society 2015 | National Comprehensive Cancer Network 2019 | U.S. Preventative Services Task Force 2016 | American College of Obstetricians and Gynecologists 2017 |
|---|---|---|---|
| ***Mammography*** | | | |
| Informed decision-making with a health care provider ages 40-44.<br>Every year starting at age 45-54.<br>Every 2 years (or every year if a woman chooses to do so) starting at age 55, for as long as a woman is in good health. | Every year starting at age 40, for as long as a woman is in good health.<br>(3D mammography – breast tomosynthesis – may be considered) | Informed decision-making with a health care provider ages 40-49.<br>Every 2 years ages 50-74.<br>Insufficient evidence in ages >75. | Offer every year starting at age 40.<br>Initiate at ages 40-49 after counseling.<br>Initiate annually no later than age 50 years.<br>May discontinue at age 75. |
| ***Clinical Breast Exam*** | | | |
| Not recommended. | Every 1-3 years ages 25-39.<br>Every year starting at age 40. | Not enough evidence to recommend for or against. | Every 1-3 years ages 25-39.<br>Every year starting at age 40. |
| ***Self Breast Exam*** | | | |
| Not recommended | Recommends breast awareness. | Not enough evidence to recommend for or against. | Recommends breast awareness. |

# EVALUATION OF A BREAST MASS

- Discovered by partner or self breast exam, CBE, or screening mammography
- History
  - How long has mass been there?
  - Nipple discharge or skin changes?
  - Trauma or injury to the area?
  - Medications?
  - Relationship to menstrual cycle?
  - Family history of breast disease
- Physical exam – if not found by provider on CBE, a thorough exam and inspection should be performed
  - Size, shape, consistency, mobility, location
- Diagnostic imaging
  - Under age 30 – breast US
  - Over 40 – diagnostic mammography with breast US as indicated
  - MRI reserved for high-risk patients
- Breast Imaging Reporting and Data System (BI-RADS) to determine need for biopsy
  - Solid masses need biopsy
    - FNA with/without US guidance
    - Core needle biopsy
    - Surgical biopsy

| BI-RADS Classification | |
|---|---|
| 0: | Unsatisfactory assessment – additional imaging needed |
| 1: | Negative findings – routine follow-up recommended |
| 2: | Benign findings – no malignancy suspected |
| 3: | Probably benign lesion – short term follow-up indicated |
| 4: | Suspicious abnormality |
| 5: | Highly suggestive of malignancy |
| 6: | Known malignancy |

# BENIGN BREAST DISEASE

| Nonproliferative Breast Lesions (Breast Cancer Risk = 1.27) | |
|---|---|
| Breast cyst (simple) | Round, ovoid fluid-filled masses; firm, mobile, well-demarcated; premenopausal women (age 35-50); influenced by hormonal changes; acute enlargement can cause pain |
| Complex cyst | Thick walls and/or septa >0.5mm on US; anechoic or echogenic; Dx with FNA/core biopsy/surgery |
| Mild hyperplasia of usual type | Increase in number of epithelial cells within a duct; Dx with FNA/core biopsy/surgery |
| **Proliferative Breast Lesions without Atypia (Breast Cancer Risk = 1.88)** | |
| Fibroadenoma | Mixed fibrous and glandular tissue; aberration of normal breast development; smooth, firm, rubbery, mobile mass; common age 15-35; Dx with core biopsy/surgery |
| Juvenile fibroadenoma | Unilateral, painless, rapidly growing solitary mass >5cm; ages 10-18; Tx with surgical excision |
| Intraductal papilloma | Wart-like growth in lactiferous ducts; small lump near nipple with clear/bloody discharge; ages 35-50; Dx with core biopsy; Tx observation vs surgical excision |
| Usual ductal hyperplasia | Increase in number of cells in duct without atypia, incidental finding on biopsy |
| Radial scars | AKA complex sclerosing lesion; fibroelastic core with radiating ducts and lobules; incidental finding |
| **Proliferative Breast Lesions with Atypia (Breast Cancer Risk = 4.24)** | |
| Atypical hyperplasia | Proliferation of dysplastic cells in ducts or lobules; 10% of biopsies; pre-malignant; Dx core biopsy; Tx with surgical excision; increased screening follow-up; avoid hormones; chemoprevention in select women |

# INTIMATE PARTNER VIOLENCE

- U.S. Preventive Service Task Force (USPSTF) Recommendation:
  - Screen women of childbearing age for intimate partner violence (IPV), such as domestic violence (DV), and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.
- According to the CDC, roughly 1.5 million women are raped and/or physically assaulted each year in the United States.
- Intimate partner violence (IPV) affects as many as 324,000 pregnant women each year.
- USPSTF screenings are directed at patients and can be self-administered or used in a clinician interview format.
- The 6 tools that showed the most sensitivity and specificity were:
  - HITS (Hurt, Insult, Threaten, Scream)
  - OVAT (Ongoing Violence Assessment Tool)
  - STaT (Slapped, Things and Threaten)
  - HARK (Humiliation, Afraid, Rape, Kick)
  - CTQ-SF (Modified Childhood Trauma Questionnaire–Short Form)
  - WAST (Woman Abuse Screen Tool)
- Other screening tools for pregnant women include 4 Ps12 and the Abuse Assessment Screen. CDC has compiled a comprehensive list of screening instruments that have been tested on various patient populations.
- Studies have shown that patient self-administered, or computerized screenings are as effective as clinician interviewing in terms of disclosure, comfort, and time spent screening.

# INTIMATE PARTNER VIOLENCE

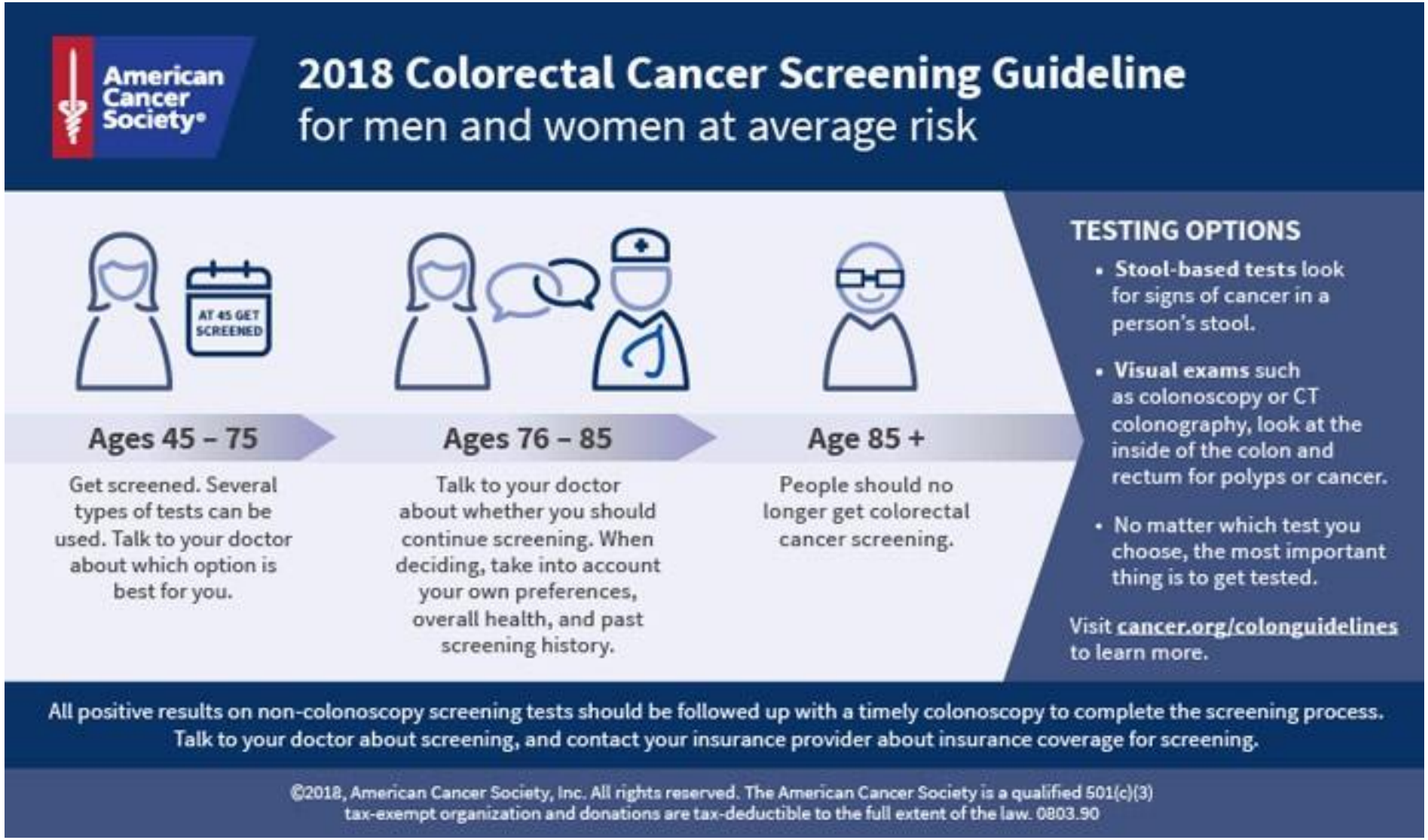
- Barriers
  - Time constraints
  - Discomfort with the topic
  - Fear of offending the patient or partner
  - Need for privacy
  - Perceived lack of power to change the problem
  - A misconception regarding patient population's risk of exposure to IPV

www.thehotline.org
1-800-799-7233

# BONE DENSITY SCREENING

- By 2020, approximately 12.3 million individuals in the United States older than 50 years are expected to have osteoporosis.
- Osteoporotic fractures, particularly hip fractures, are associated with limitations in ambulation, chronic pain and disability, loss of independence, and decreased quality of life, and 21% to 30% of patients who experience a hip fracture die within 1 year.
- The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.
- The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.
- The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis to prevent osteoporotic fractures in men.
  - Endocrine Society recommends for men ages >70 years
- ACOG recommends selective screening in postmenopausal women younger than 65 years who have osteoporosis risk factors or an adult fracture

# COLON CANCER SCREENING

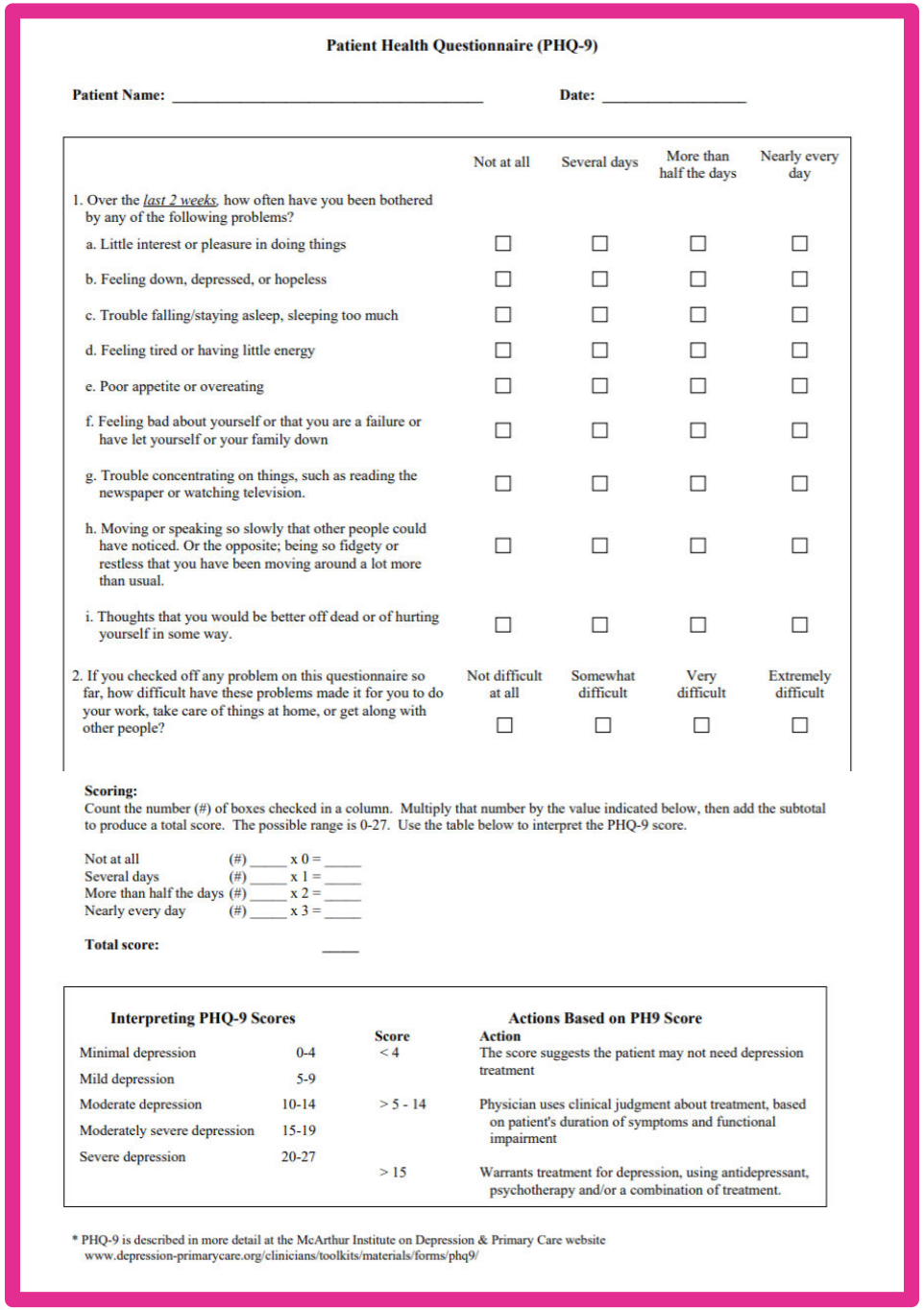


# COLON CANCER SCREENING

- People at average risk of colorectal cancer should start regular screening at age 45.
- People who are in good health and with a life expectancy of more than 10 years should continue regular colorectal cancer screening through the age of 75.
- People ages 76 through 85 should make a decision with their medical provider about whether to be screened, based on their own personal preferences, life expectancy, overall health, and prior screening history.
- People over 85 should no longer get colorectal cancer screening.
- What are the tests?
  - Stool-based tests:
    - Highly sensitive fecal immunochemical test (FIT) every year
    - Highly sensitive guaiac-based fecal occult blood test (gFOBT) every year
    - Multi-targeted stool DNA test (MT-sDNA) every 3 years
  - Visual exams:
    - Colonoscopy every 10 years
    - CT colonography (virtual colonoscopy) every 5 years
    - Flexible sigmoidoscopy (FSIG) every 5 years

# DEPRESSION

- The USPSTF recommends screening in all adults regardless of risk factors.
- Among older adults, risk factors for depression include disability and poor health status related to medical illness, complicated grief, chronic sleep disturbance, loneliness, and a history of depression.
- Risk factors for depression during pregnancy and postpartum
  - poor self-esteem
  - child-care stress
  - prenatal anxiety
  - life stress
  - decreased social support
  - single/unpartnered relationship status
  - history of depression
  - difficult infant temperament
  - previous postpartum depression
  - lower socioeconomic status
  - unintended pregnancy.



**Patient Health Questionnaire (PHQ-9)**

**Patient Name:** _____ **Date:** _____

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems? | | | | |
| a. Little interest or pleasure in doing things | ☐ | ☐ | ☐ | ☐ |
| b. Feeling down, depressed, or hopeless | ☐ | ☐ | ☐ | ☐ |
| c. Trouble falling/staying asleep, sleeping too much | ☐ | ☐ | ☐ | ☐ |
| d. Feeling tired or having little energy | ☐ | ☐ | ☐ | ☐ |
| e. Poor appetite or overeating | ☐ | ☐ | ☐ | ☐ |
| f. Feeling bad about yourself or that you are a failure or have let yourself or your family down | ☐ | ☐ | ☐ | ☐ |
| g. Trouble concentrating on things, such as reading the newspaper or watching television. | ☐ | ☐ | ☐ | ☐ |
| h. 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. | ☐ | ☐ | ☐ | ☐ |
| i. Thoughts that you would be better off dead or of hurting yourself in some way. | ☐ | ☐ | ☐ | ☐ |
| 2. If you checked off any problem on this questionnaire so far, 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 |
| | ☐ | ☐ | ☐ | ☐ |

**Scoring:**
Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

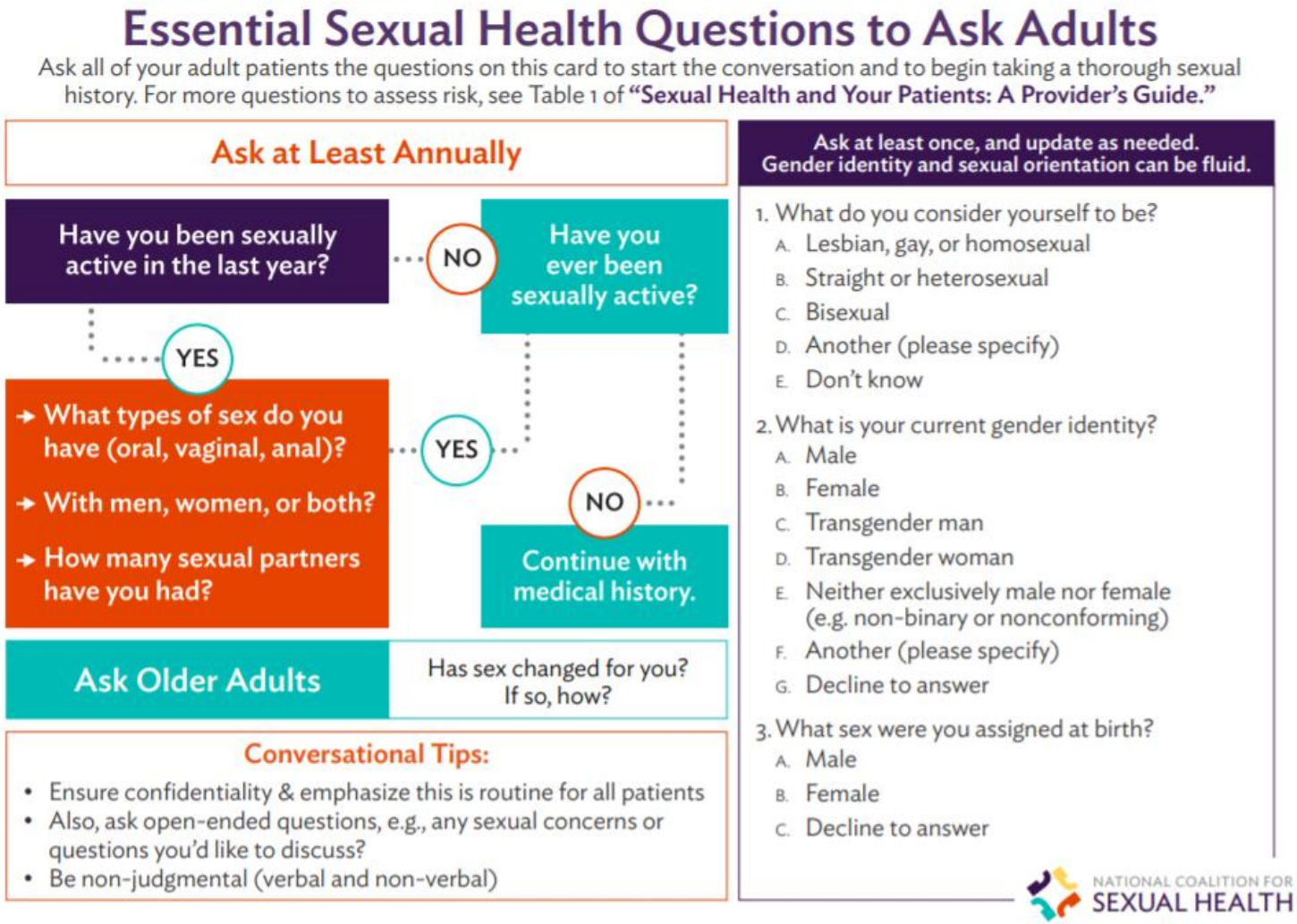
Not at all (#) _____ x 0 = _____
Several days (#) _____ x 1 = _____
More than half the days (#) _____ x 2 = _____
Nearly every day (#) _____ x 3 = _____

**Total score:** _____

| Interpreting PHQ-9 Scores | | Actions Based on PH9 Score | |
|---|---|---|---|
| | | **Score** | **Action** |
| Minimal depression | 0-4 | < 4 | The score suggests the patient may not need depression treatment |
| Mild depression | 5-9 | | |
| Moderate depression | 10-14 | > 5 - 14 | Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment |
| Moderately severe depression | 15-19 | | |
| Severe depression | 20-27 | | |
| | | > 15 | Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment. |

* PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/

# SEXUAL HEALTH SCREENING



# SEXUAL HEALTH SCREENING

## Recommended Preventive Sexual Health Services for Adults

| Service | Females | | | Males | | | Transgender Individuals |
|---|---|---|---|---|---|---|---|
| | 18-64 | 65+ | Pregnant | 18-64 | 65+ | MSM | |
| STI Counseling | ✓a | ✓a | ✓a | ✓a | ✓a | ✓a | ✓a |
| Contraceptive Counseling | ✓ | | ✓ | ✓ | ✓ | | ✓ |
| Cervical Cancer Screening | ✓b | ✓b | ✓b | | | | ✓c |
| Chlamydia Screening | ✓d | ✓d | ✓d | ✓e | | ✓f | ✓a |
| Gonorrhea Screening | ✓d | ✓d | ✓d | | | ✓g | ✓a |
| HIV Testing | ✓ | ✓a | ✓ | ✓ | ✓a | ✓ | ✓ |
| Syphilis Screening | ✓h | ✓h | ✓ | ✓h | ✓h | ✓ | ✓h |
| Hepatitis B Screening | ✓i | ✓i | ✓ | ✓i | ✓i | ✓ | ✓i |
| Hepatitis C Screening | ✓jk | ✓jk | ✓j | ✓jk | ✓jk | ✓jk | ✓jk |
| Hepatitis A Vaccine | ✓l | ✓l | ✓l | ✓l | ✓l | ✓ | ✓l |
| Hepatitis B Vaccine | ✓m | ✓m | ✓m | ✓m | ✓m | ✓ | ✓m |
| HPV Vaccine | ✓n | | | ✓n | | ✓n | ✓n |
| PrEP | ✓* | ✓* | ✓* | ✓* | ✓* | ✓* | ✓* |

**a =** At increased risk: inconsistent condom use, multiple partners, partner with concurrent partners, current STI, or history of STI within a year

**b =** Aged 21 to 65 or when adequate screening history has been established

**c =** FTM transgender patients who still have a cervix according to guidelines for non-transgender women

**d =** Sexually-active women aged <25; women aged ≥25 at increased risk

**e =** Young adult males in high-prevalence communities or settings

**f =** Screen for urethral infection if insertive anal sex in preceding year; rectal infection if receptive anal sex in preceding year

**g=** Screen for urethral infection if insertive anal sex in preceding year; rectal infection if receptive anal sex in preceding year; pharyngeal infection if receptive oral sex in preceding year

**h =** HIV-positive; at increased risk: exchange sex for drugs or money; in high prevalence communities

**i =** At risk: HIV-positive, unprotected sex, share needles, family member or sexual partner infected with HBV; born in a HBV-endemic country; born to parents from a HBV-endemic country

**j =** HIV-positive, history of injection or intranasal drug use or incarnation; blood transfusion prior to 1992

**k =** Born between 1945 and 1965 (at least once)

**l =** Use illicit drugs; have chronic liver disease; receive clotting factors; travel to HAV-endemic countries; wish to be vaccinated

**m =** At risk: multiple partners, share needles, family member or sexual partner infected with HBV

**n =** Women and men aged ≤45

*** =** HIV-negative and at substantial risk for HIV infection (sexual partner with HIV, injection drug user, recent bacterial STI, high number of sex partners, commercial sex worker, lives in high-prevalence area or network)

For more information, visit: **nationalcoalitionforsexualhealth.org**

# SEXUAL HEALTH SCREENING

## Essential Sexual Health Questions to Ask Adolescents

Ask all your adolescent patients the sexual health questions on this card. This will help you assess your patient's level of sexual risk and determine which additional questions to ask and which preventive services are needed (other side of card).

### Ask at Least Annually

1. What questions do you have about your body and/or sex?
2. Your body changes a lot during adolescence, and although this is normal, it can also be confusing. Some of my patients feel as though they're more of a boy or a girl, or even something else, while their body changes in another way. How has this been for you?
3. Some patients your age are exploring new relationships. Who do you find yourself attracted to? (Or, you could ask, "How would you describe your sexual orientation?")
4. Have you ever had sex with someone? By "sex," I mean vaginal, oral, or anal sex. (If sexual activity has already been established, ask about sex in the past year.)

### If the Adolescent Has Had Sex, Ask About

- ✓ Number of lifetime partners
- ✓ Number of partners in the past year
- ✓ The gender of those partners
- ✓ The types of sex (vaginal, oral, anal)
- ✓ Use of protection (condoms and contraception)
- ✓ Coercion, rape, statutory rape, and incest

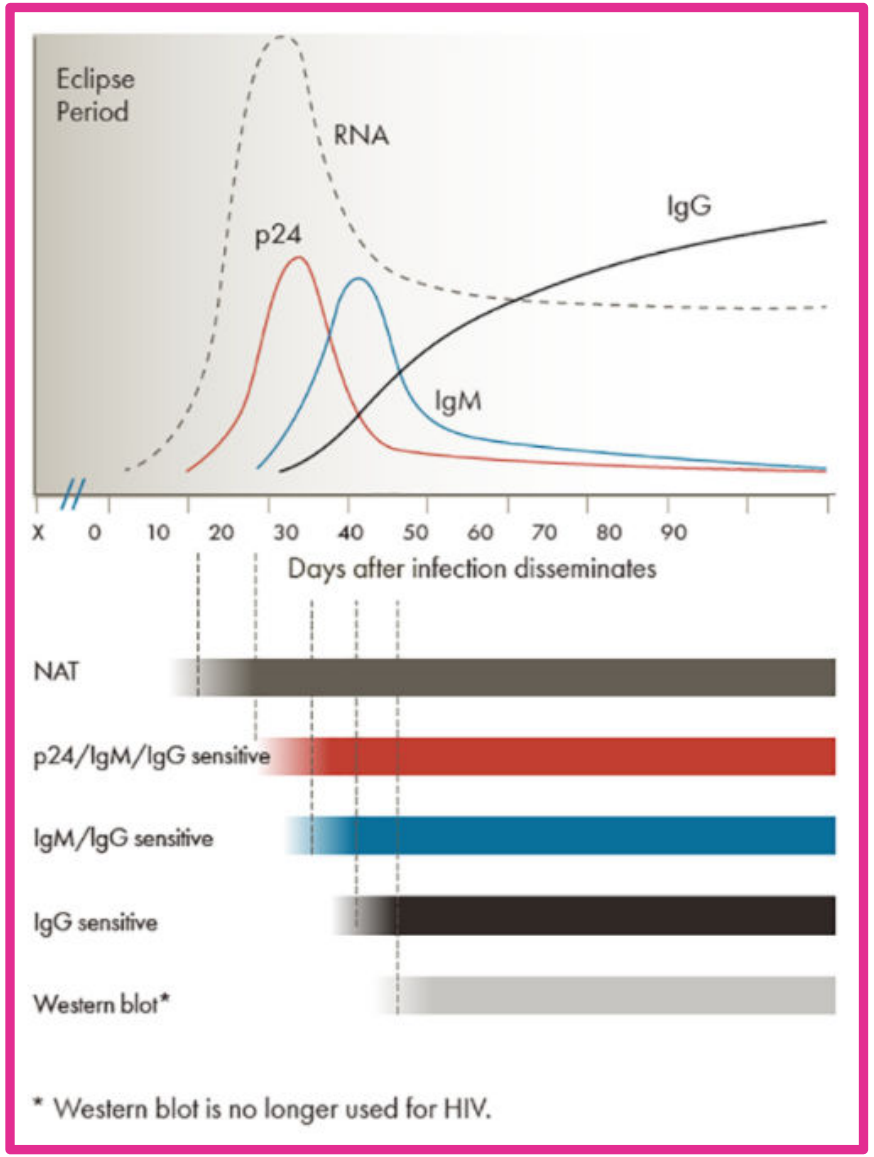
### Prepare for the Sexual History Interview

- ✓ Explain to a parent or caregiver that you spend a portion of each visit alone with the adolescent.
- ✓ Put your patient at ease. Ensure confidentiality except if the adolescent intends to inflict harm or reports being abused. Know your state's laws that affect minor consent and patient confidentiality.
- ✓ Incorporate the four essential sexual health questions into a broader psychosocial history.
- ✓ Start with less threatening topics, such as school or activities, before progressing to more sensitive topics, such as drugs and sexuality.
- ✓ Use open-ended questions, rather than closed-ended, to better facilitate conversation.
- ✓ Listen for strengths and positive behaviors and for opportunities to give praise where praise is due.

NATIONAL COALITION FOR SEXUAL HEALTH

# HIV SCREENING

- An estimated 1.1 million people in the United States have HIV and approximately 1 in 7 (nearly 15%) are unaware of their status
- About 40% of new HIV infections are transmitted by people undiagnosed and unaware they have HIV
- CDC recommends that EVERYONE between the ages of 13 and 64 get tested for HIV at least once as part of routine health care
- For those at higher risk, CDC recommends getting tested at least once a year
- Missed opportunities
  - More than 75% of patients at high risk for HIV who saw a PCP in the last year weren't offered an HIV test during their visit.
- Treatment
  - PrEP – Pre-Exposure Prophylaxis
  - PEP – Post-Exposure Prophylaxis
  - Active HIV/AIDS



# BARRIERS TO SEX POSITIVITY



Sexism



Sexual Violence



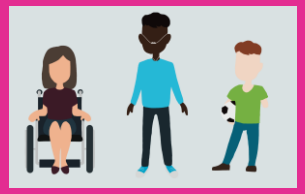

Taboo, Shame, Stigma




Racism



Heteronormativity
Homophobia



Ableism



Ageism




Sizeism

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ALEECE@FOSNIGHTCENTER.COM
WWW.FOSNIGHTCENTER.COM

# THANK YOU!