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I General Obstetrics and Gynecology

CHAPTER 1

Women's Health Examination and Women's Health Care Management

This chapter deals primarily with APGO Educational Topic Areas:

TOPIC 1	HISTORY
TOPIC 2	EXAMINATION
TOPIC 3	CERVICAL CYTOLOGY SCREENING AND DNA PROBES/CULTURES
TOPIC 4	DIAGNOSIS AND MANAGEMENT PLAN
TOPIC 5	PERSONAL INTERACTION AND COMMUNICATION SKILLS

Students should be able to refine their communication and clinical care skills in taking a pertinent comprehensive medical history and assessing risk and patient adherence to health care recommendations. They should be able to perform a comprehensive breast and pelvic exam, including cervical cytology (Papanicolaou or Pap test) screening and other appropriate tests. They should be able to use this information to formulate a diagnosis and management plan while communicating important findings and recommendations to the patient, incorporating their socioeconomic and cultural context as well as their gender identity and sexual orientation (heterosexual, lesbian, gay, bisexual, nonbinary, or transgender).

CLINICAL CASE

On a pleasant, rather warm summer's day, a 72-year-old woman comes to your office with her daughter for her "annual examination." She is happy, alert, and in a brightly colored dress matched with a heavy sweater. Your notes indicate that she used to use your office for her general as well as gynecologic health care, but it has been over 7 years since her last visit. Review of her records shows a pattern of general good health with two successful term pregnancies and a postpartum tubal ligation during her twenties followed at age 38 years by a diagnostic laparoscopy for pelvic pain and heavy menstrual bleeding that revealed multiple uterine fibroids and very mild endometriosis. After reviewing multiple treatment options, she decided to proceed with a total abdominal hysterectomy without oophorectomy, and her mild endometriosis was successfully treated with nonsteroidal anti-inflammatory medications until menopause at age 49 years. All previous cervical cytology screening, laboratory, and imaging studies were normal. She is 5 feet 4 in tall and weighs 152 lb—an increase of 10 lb since you last saw her. Her blood pressure is 112/65 mm Hg with normal pulse, temperature, and respiration. Her interval history and review of systems (ROS) are unremarkable except for frequent reports of feeling cold and her skin feeling drier than previously. Her physical examination is unremarkable. She asks for her sweater while waiting for her examination, reporting that she is cold and tells you she is worried about being overweight because

she has gained a few pounds over the past few years. Her daughter remarks that her mother reports constantly that the temperature of her room is set too low.

INTRODUCTION

Obstetrics was originally a separate branch of medicine, and **gynecology** was a division of surgery. Over time, an increasing knowledge of the pathophysiology of the female reproductive tract led to a natural integration of these two areas, and obstetrics and gynecology merged into a single specialty. After completing an approved residency, the obstetrics and gynecology specialist may practice *general obstetrics* (care of the pregnant patient during pregnancy, labor, and the postpartum period) and *gynecology* (traditionally care of the female reproductive organs and breasts but now encompassing comprehensive women's health care from before puberty to beyond the menopause). They may also choose subspecialty practice by completing fellowships in any of the four subspecialty areas recognized by the American Board of Obstetrics and Gynecology (ABOG).

Maternal-fetal medicine deals with high-risk pregnancies and prenatal diagnosis.

Gynecologic oncology focuses on the treatment of malignancy of the reproductive tract and associated organ systems.

Reproductive endocrinology–infertility addresses problems in conception and gynecologic endocrine disease.

Female pelvic medicine and reconstructive surgery (often referred to as *urogynecology*) focuses on the management of patients with pelvic floor disorders, such as urinary incontinence and pelvic organ prolapse.

Currently, many obstetrician-gynecologists also provide routine general medical care for women throughout their lives. Thus, obstetrician-gynecologists must have additional knowledge and skills in the primary and preventive health care needs of women and must be able to identify situations where they may provide care and those in which referral to other specialists is

appropriate. The demographics of women in the United States are undergoing profound change. A woman born today will live 81 or more years on average, experiencing menopause at age 51 to 52 years. Unlike previous generations, women will spend more than one-third of their lives in menopause. The absolute number and the proportion of all women over age 65 years are projected to increase steadily through 2050 (Figure 1.1). These women will expect to remain healthy (physically, intellectually, emotionally, and mentally) throughout their lives including their "menopause years." Physicians must keep the needs of this changing population in mind in their practice of medicine, especially in the provision of primary and preventive gynecologic care.

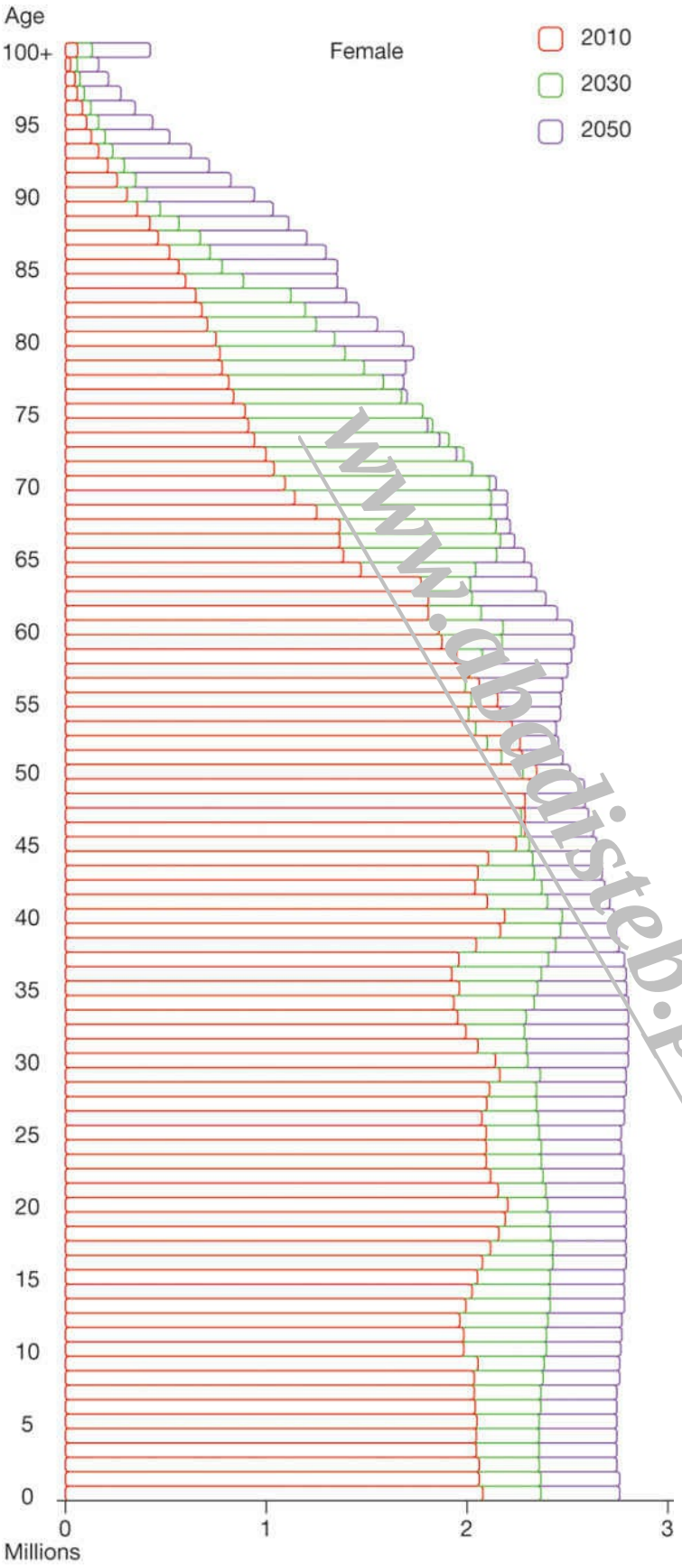

FIGURE 1.1. The US population demographics. (Adapted from the U.S. Census Bureau.)

Obstetrician-gynecologists must be able to establish an empathic, trusting professional relationship with patients and be able to perform a general and women's health history and physical examination using this information to formulate a comprehensive management plan. Finally, obstetrician-gynecologists must fully understand the concepts of evidence-based medicine and incorporate them into their scholarship and practice in the context of a well-established pattern of lifelong learning and self-evaluation.

This chapter directly addresses the initial or "new patient visit" for gynecology and primary/preventive care as well as a first visit for obstetric care (a "new OB" visit). Subsequent return visits are generally shorter and more focused. Obtaining complete information is essential for good health care. Age-appropriate health care screening and preventive and primary health care are discussed in Chapter 2. An up-to-date comprehensive medical record should include information from history taking, physical examination, and laboratory and radiology testing. Information from referrals and other medical services outside the purview of the obstetrician-gynecologist should be integrated into the medical record.

ESTABLISHING AN EFFECTIVE PATIENT-PHYSICIAN PARTNERSHIP

The patient encounter begins with an appropriate greeting that deserves special attention because of the importance of initial impressions at the start of the patient-physician partnership to promote high-quality health care outcomes. Table 1.1 provides an example of an introduction that is designed to allow for open empathic communication.

TABLE 1.1 **ESTABLISHING AN EFFECTIVE PATIENT-PHYSICIAN PARTNERSHIP**

Stage	Sample Statement or Question	Advantage
Introduction: After verifying the patient's identity, the patient should be asked how they prefer to be addressed—by first name, surname, nickname, or pronouns.	Hello, I'm Kelly Garcia. Are you Terry Moore? How would you like to be addressed?	To the older patient, this may show respect and offer the opportunity to ask you to use "Mrs Moore," rather than "Terry." The younger patient may want to use a nickname. The LGBT patient may see this as an opportunity to offer a new name that conforms to their gender identity.
	Do you feel comfortable sharing your pronouns with me? Mine are he, him, his (if you feel comfortable).	This shows the LGBT patient that you are willing to listen and engage in a conversation about their sexual orientation and gender identity.
	I like to have my patients feel as comfortable as possible, so if at any time I misspeak, let me know.	This statement demonstrates cultural humility.
Reason for the visit	"What brings you in	A friendly but neutral greeting allows the patient to frame their

	today?" A handshake is commonly used.	response in a comfortable environment, be it a problem, a concern, or another issue.

Using *empathic communication skills*, physicians strive to "project" themselves into the patient's life and imagine the situation from the patient's point of view. Thus, empathy goes beyond sympathy wherein the physician knows the patient's emotions from their side of the partnership but does not view or feel them from the unique perspective of the patient. Empathic communication promotes the physician's fullest understanding of the patient's situation. It improves trust, the quality of information (and, thus, diagnostic accuracy), patient adherence to the decisions the patient and physician make, and the satisfaction of both the patient and the physician. Empathic communication is a learned skill that facilitates good patient-physician partnership and the most efficient use of the time available for patient encounters.

Another characteristic of a good patient-physician partnership is that the physician spends more time listening than talking during the first two-thirds of a patient visit. This kind of communication replaces the traditional approach of "advice giving" and gives way to "reflective listening." The patient is encouraged to talk and the physician actively listens, periodically confirming what has been heard. Because the information gained is of better quality and the patient's needs are met during the encounter, time-consuming "late-arising concerns" (significant issues brought up after a degree of closure has been reached on the primary problems) are less likely to occur. Building a strong and trusting patient-physician partnership is central to good women's health care.

WOMEN'S HEALTH EVALUATION: HISTORY AND PHYSICAL EXAMINATION

When organized effectively, data gathered during a patient's health

evaluation are critical in facilitating patient management. Record keeping is now turning to electronic medical records, whose advantages include elimination of both transcription errors and illegible information, automated follow-up with reminders of tests and consultations, simultaneous creation of billing information, and organization and rapid availability of an entire patient's chart.

Medical History

The medical history includes the chief complaint, problem, or concern; history of present illness (HPI); a past history that includes a gynecologic history, obstetric history, family health history, and social history; and ROS.

Reason for Encounter

The **reason for encounter (RFE)** is a concise statement describing the symptom, problem, condition, diagnosis, physician-recommended return, or other reasons for the patient visit. A CC may not be present if the patient is seeing the obstetrician-gynecologist for preventive care. *Note:* Although the term "chief complaint" is commonly used in medicine, it is preferable to refer to patients reporting (rather than complaining about) signs and symptoms they have experienced. The RFE was previously referred to as the Chief Complaint.

History of Present Illness

The **history of present illness (HPI)** is a chronologic description of the development of the patient's reported signs and symptoms; if the office visit is for primary care, chronology applies to the other components of the history. Establishing *chronology* can be important because chronologic organization often suggests a specific disease or narrows consideration of illness to an organ system. Sometimes, the onset of symptoms is easily identified because of its abruptness. In other cases, the onset is insidious, making it difficult for a patient to identify a specific time. When the onset of symptoms is slow, patients are often unable to accurately identify when the symptom began. Asking in the context of a recognizable date prior to the visit

(eg, a holiday) will often allow the patient to provide better chronologic information. This technique may be useful in any history taking and not just for the initial reporting of signs and symptoms.

Past History

Past history includes information about sexual health history as well as medical, surgical, or psychiatric illnesses and/or treatments the patient has had, including the diagnosis, the medical and/or surgical treatment, and the results. Questions about previous surgery of any kind should include the name of the procedure, indication; when, where, and by whom the surgery was performed; and the results. The clinician should always be cognizant that past medical histories filled out in advance of the visit, either at home or in the waiting room, may not contain complete information. Patients may not remember all their diagnoses, surgeries, or procedures, or may choose to omit some of them owing to shame, distrust, or fear. This is often the case with sexually transmitted infections (STIs), unplanned pregnancies that ended in adoption or termination, and gender-affirming surgeries. Intake forms should always be verified, and after establishing rapport, the interviewer might ask if there are any other issues in the past medical history that the patient wants to discuss.

Operative notes may contain useful information. A previous surgeon's notes describing findings consistent with the effects of a pelvic infection should prompt the physician to ask specifically about a history of STIs, such as gonorrhea (GC) or *chlamydia*, that can cause these findings. This should prompt the interviewer to also ask about previous cases of herpes, genital warts, hepatitis, AIDS, and syphilis as well as about vaginitis and vaginal discomfort. Vaginitis and STIs are often confused. Careful history taking is needed to differentiate vaginitis or cervicitis from pelvic inflammatory disease. This can avoid delays in appropriate evaluation and treatment, which can have long-term impact on a patient's reproductive health.

Explaining the differences while obtaining this history is an excellent opportunity to use empathic and motivational communication skills to build and enhance the patient-physician partnership. The patient's immunization history should be obtained to update adult immunization schedules and discuss new vaccines like the human papillomavirus (HPV) vaccine.

Gynecologic History

Gynecologic history includes the menstrual history, which begins with **menarche**, the age at which menses began. The basic **menstrual history** includes the following:

- Last menstrual period
- Length of periods (number of days of bleeding)
- Number of days between periods
- Any recent changes in periods

Episodes of bleeding that are "light but on time" should be noted as such because they may have diagnostic significance. Sometimes, women disregard such an episode when asked when they last had a menstrual period; therefore, it is often useful to specifically ask if there had been any "light" bleeding, which may represent an actual ovulatory cycle. Determining a last menstrual period may be made difficult by an episode of "light vaginal bleeding." Specific questioning is often helpful in understanding whether a patient's last menstrual cycle was normal or abnormal. Estimation of the amount of menstrual flow can be made by asking whether the patient uses pads or tampons, how many are used during the heavy days of her flow, and whether they are soaked or just soiled when they are changed. It is normal for women to pass clots during menstruation, but usually they should not be larger than the size of a dime. Specific inquiry should be made about **irregular bleeding** (bleeding with no set pattern or duration), **intermenstrual bleeding** (bleeding between menses), and **postcoital bleeding** (bleeding immediately after coitus).

The menstrual history may include **premenstrual symptoms**, such as anxiety, fluid retention, nervousness, mood fluctuations, food cravings, variations in sexual feelings, and difficulty sleeping. Cramps and discomfort during menses are common but abnormal when they interfere with daily activities of living or when they require more analgesia than provided by nonnarcotic analgesia. Menstrual pain is mediated through prostaglandins and should be responsive to nonsteroidal anti-inflammatory drugs. Inquiry about duration (both how long the patient has noted this pain and how long each episode of pain lasts), quality, radiation of the pain to areas outside the pelvis,

and association with body position or daily activities completes the pain history.

The term **menopause** refers to the cessation of menses for greater than 1 year. **Perimenopause** is the time of transition from menstrual to nonmenstrual life when ovarian function begins to wane, often lasting 1 to 2 years. Significant and disruptive perimenopausal symptoms are often disturbing and require focused attention when they are identified. Timely specific treatment is often indicated. The perimenopausal period often begins with increasing menstrual irregularity and varying or decreased flow and is associated with hot flushes, nervousness, mood changes, and decreased vaginal lubrication with sexual activity as well as altered libido (see Chapter 41).

The gynecologic history includes known gynecologic illnesses and how they were treated. The history also lists surgeries the patient has had, including what was done, why it was done, when it was done, and by whom. These details are often available by obtaining copies of the surgical dictations (operative reports), which often provide crucial diagnostic information.

Pause, Think, and Apply

1.1 Your patient is a 29-year-old G0 referred by her family medicine doctor for evaluation of infertility.

Which menstrual history below would warrant further evaluation of her lipids and HgA_{1c}?

A. Menarche at age 8 years with regular periods every 28 to 32 days lasting 5 days

B. Menarche at age 14 years with regular periods every 30 to 34 days lasting 7 days

C. Menarche at age 16 years with irregular periods every 40 to 60 days lasting 5 to 10 days

D. Menarche at age 18 years with regular periods every 28 to 32 days lasting 5 to 10 days

Note: The answers to the Pause, Think, and Apply questions are

included at the end of the chapter.

Sexual History

The gynecologic history also includes a **sexual history**. The physician should be well versed in the differences between sex and gender. Although sex and gender are often used interchangeably, **sex** is a biological construct referring to biological and physiologic characteristics of males and females, such as chromosomes, reproductive organs, and hormones. Infants are generally assigned a sex at birth. **Gender** is a social, psychologic, and cultural construct related to an individual's own identity and how they relate to their environment in terms of social norms, roles, and relationships between groups of individuals. It is essential to separate sex and gender from sexual orientation, which relates to self-identified patterns of emotional, romantic, and sexual attraction. See Box 1.1 for some helpful definitions.

BOX 1.1 Terminology and Definitions for Transgender and Gender-Diverse Individuals

Chest feeding: Some masculine-identified individuals use this term to describe the act of feeding their child from their chest regardless of whether they have had chest surgery.

Cisgender: A term used to describe a person whose gender identity aligns with those typically associated with the sex assigned to them at birth.

Gender identity: A person's internal sense of self and how they fit into the world, from the perspective of gender.

Gender dysphoria: Distress that accompanies the incongruence between one's experienced and expressed gender and one's assigned or natal gender.

Gender expression: The outward manner in which individuals express or display their gender. This may include choices in clothing and hairstyle or speech and mannerisms. Gender identity and gender expression may differ; for example, a woman (transgender or cisgender) may have an

androgynous appearance, or a man (transgender or cisgender) may have a feminine form of self-expression.

Transgender: A person whose gender identity differs from the sex that was assigned at birth. May be abbreviated to trans. A transgender man is someone with a male gender identity and a female birth assigned sex; a transgender woman is someone with a female gender identity and a male birth assigned sex. A nontransgender person may be referred to as cisgender (cis means same side in Latin).

Gender nonconforming: A person whose gender identity differs from that which was assigned at birth, but may be more complex, fluid, multifaceted, or otherwise less clearly defined than a transgender person.

Genderqueer: Blurring the lines around gender identity and sexual orientation. Genderqueer individuals typically embrace a fluidity of gender identity and sometimes sexual orientation.

Nonbinary: Transgender or gender nonconforming person who identifies as neither male nor female

Sex: Historically has referred to the sex assigned at birth, based on assessment of external genitalia, as well as chromosomes and gonads. In everyday language is often used interchangeably with gender, however there are differences, which become important in the context of transgender people.

Sexual orientation: Describes sexual attraction only and is not directly related to gender identity. The sexual orientation of transgender people should be defined by the individual. It is often described based on the lived gender; a transgender woman attracted to other women would be a lesbian, and a transgender man attracted to other men would be a gay man.

Gender fluidity: Having different gender identities at different times

Agender: "Without gender"; individuals identifying as having no gender identity

Gender expansiveness: Conveys a wider, more flexible range of gender identity or expression than typically associated with the binary gender system

Transmasculine and transfeminine: Terms to describe gender nonconforming or nonbinary persons, based on the directionality of their gender identity. A transmasculine person has a masculine spectrum

gender identity, with the sex of female listed on their original birth certificate. A transfeminine person has a feminine spectrum gender identity, with the sex of male listed on their original birth certificate. In portions of these Guidelines, in the interest of brevity and clarity, transgender men or women are inclusive of gender nonconforming or nonbinary persons on the respective spectra.

They/them/their: Neutral pronouns used by some who have a nonbinary or nonconforming gender identity.

Transsexual: A more clinical term which had historically been used to describe those transgender people who sought medical intervention (hormones, surgery) for gender affirmation. This term is less commonly used in present day, however, some individuals and communities maintain a strong and affirmative connection to this term.

Cross dresser/drag queen/drag king: These terms generally refer to those who may wear the clothing of a gender that differs from the sex which they were assigned at birth for entertainment, self-expression, or sexual pleasure. Some cross dressers and people who dress in drag may exhibit an overlap with components of a transgender identity. The term *transvestite* is no longer used in the English language and is considered pejorative.

Adapted from Human Rights Campaign. Glossary of terms. Accessed June 1, 2020. http://www.hrc.org/resources/glossary-of-terms; MacDonald T. *Transgender Parents and Chest/Breastfeeding*. KellyMom; 2018. Accessed June 18, 2020. https://kellymom.com/bf/got-milk/transgender-parents-chestbreastfeeding/; UCSF Transgender Care. Terminology and definitions. In: Deutsch MB, ed. *Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People*. 2nd ed. UCSF Transgender Care; 2016:15-16. Accessed June 18, 2020. https://transcare.ucsf.edu/guidelines/terminology; Human Rights Campaign. *New Facebook Gender Options Validated by HRC Report on Gender Expansive Youth*. HRC; 2014. Accessed June 18, 2020. https://www.hrc.org/press/new-facebook-gender-options-validated-by-hrc-report-on-gender-expansive-you; and American Psychiatric Association. *What Is Gender Dysphoria?* APA; 2016. Accessed May 28, 2020. https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria

Source: Reprinted with permission from ACOG Committee Opinion Number 823, March 2021. https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/03/health-care-for-transgender-and-gender-diverse-individuals

The goal of the sexual history is to allow the patient to share their identity