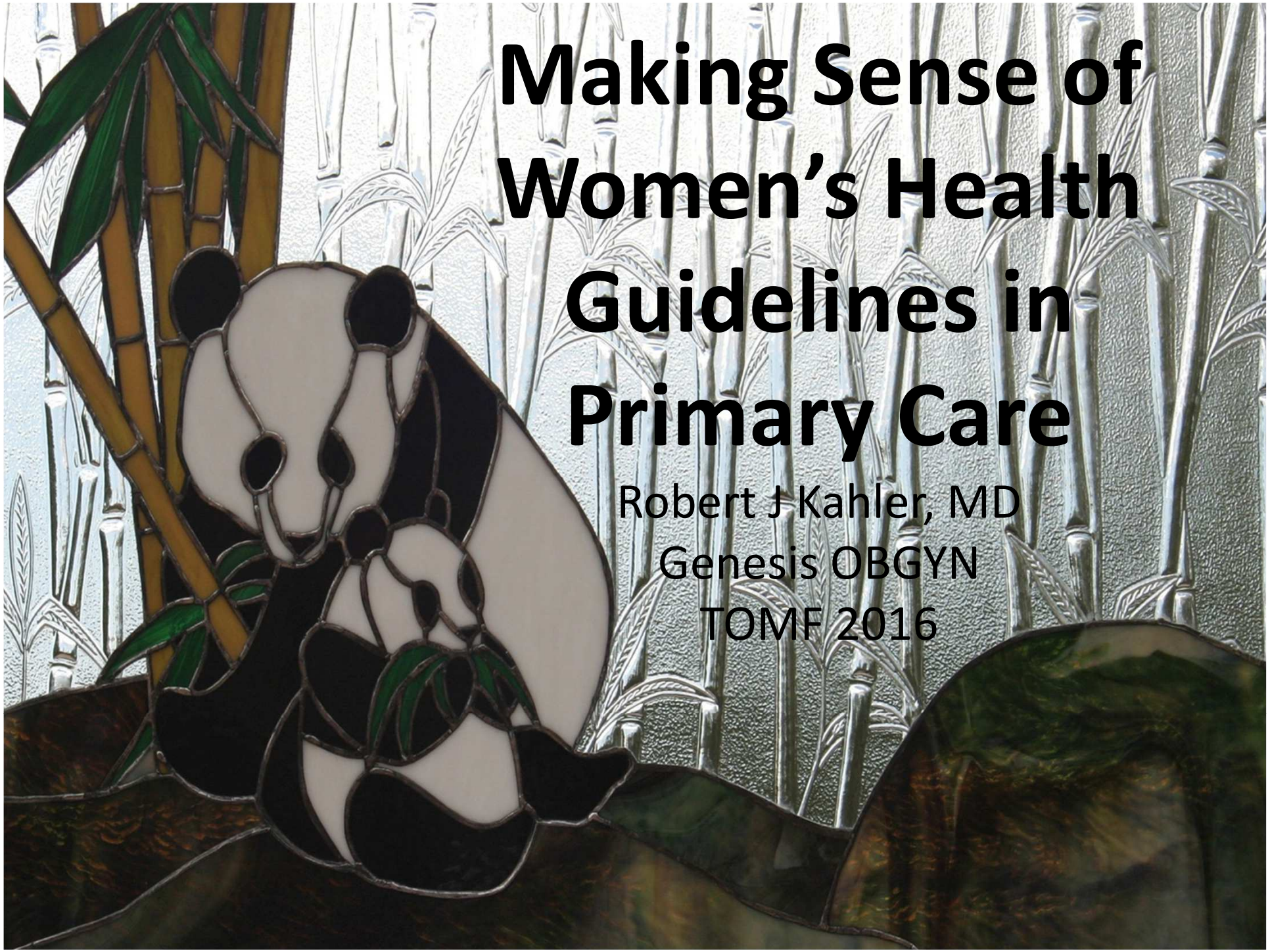

Making Sense of Women's Health Guidelines in Primary Care

Robert J Kahler, MD
Genesis OBGYN

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Guidelines should

- Improve patient care by maximizing screening benefits while minimizing harms
- Reduce stress for the provider and patient by simplifying guidance for clinical decision making
- Be easy to access

Guidelines

- Vary by the presenting organization
  - Sometimes by nuance
  - Sometimes in a major way
- Aren't available
  - Abnormal uterine bleeding
- Aren't guidelines at all
  - >4mm endometrial echo as abnormal for all

Some guidelines

- Screening
  - Pap
  - Screening Mammogram
  - Hereditary Cancer Syndromes testing
  - Annual Exam
- Therapeutic
  - Medical Eligibility Criteria for Contraception
  - HT: Menopause.org
- Incidental findings on imaging
  - Incidental ovarian cysts
  - “Thickened endometrium”

Guidelines

- Reason for the guideline
- Organizations presenting them and access
- The Guidelines
- 4th down and 10

Pap smear

- Started in 1940's as cytology to find cervix cancer
- Now includes hrHPV co-testing to identify cancer precursors
- 2012 Guidelines developed by several organizations and published by all
- Interim guidance being discussed and published

Pap screening with hx of normal

- ASCCP.org
- Don’t start until age 21
  - Risk of cervical cancer is a few per million
  - Much higher risk of harm than good
- 21-30 yo Cytology with reflex hrHPV
  - Don’t look for hrHPV unless pap ASCUS
- Age 30-65
  - Co-test Pap and hrHPV every 5 years (preferred)
  - Pap/reflex every 3 years (acceptable)

Pap screening with hx of normal

- Stop
  - Age 65 with a satisfactory history of normals
  - After hysterectomy

- Continue Pap for 20 years despite the above after HSIL or cancer

Pap – abnormal

- ASCUS with negative hrHPV is now considered normal.
  - Return to routine testing q 3-5 yrs.
- Cytology negative, hrHPV+
  - Unknown or Negative for type 16 or 18:
    - repeat co-testing in 12 mo.
- Refer all others for colposcopy

Pap screening

- Interim guidance is discussing hrHPV testing with reflex to pap when abnormal
  - A negative hrHPV test has a lower risk of CIN3+ than negative cytology
  - Huh WK, et al, Use of Primary hrHPV Testing for Cervical Cancer Screening: Interim Clinical Guidance.. OG 2015;125:330-7

- 4th down:
  - Pap with HRHPV testing every 3-5 years
    - Kinney W, et al, Increased Cervical Cancer Risk Associated With Screening at Longer Intervals. OG 2015;125:311-15
  - Not annually

- hrHPV vaccine age 9-26

Medical Eligibility Criteria for Contraception

- Understand the appropriateness of different contraceptive methods in pts with various health issues
- Over half age 15-34 and 70% age 34-45 w/ medical conditions were w/o Rx contraception, LARC, or sterilization

MEC

CDC MEC for Contraceptive use, 2010. MMWR 2010;59(No. RR-4)

Scale 1-4

1: No restriction

2: Benefits outweigh risks

3: Risks usually outweigh benefits

4: Unacceptable

MEC

- Example:
  - Family history of VTE is a 1 for all but OC (2)
  - FVL carrier is a 4 for OC, 2 for Mirena or DMPA, 1 for CuT IUD

- 4th down: Recommend at least barrier contraception and refer to gyn

Incidental ovarian cysts

- Frequently found on imaging for other reasons
- Actions available
  - No further action required
  - Observation with repeat imaging at interval
  - Referral for surgery
    - Benign Gyn vs GynOnc
- Society of Radiologists in Ultrasound
  - Levine D, et al, Management of Asymptomatic Ovarian and Other Adnexal Cysts Imaged at US: SRU Consensus Conf Statement. Ultrasound Quarterly 2010;26:121-131

Incidental ovarian cysts

- Pre-menopausal
  - Ovarian activity (not “cyst”): No imaging f/u
    - Follicle up to 30mm
    - Corpus luteum
    - Knowing menstrual timing, use of OC, DMPA helpful
  - Benign appearing functional cyst
    - “Simple”: <7cm, unilocular, anechoic, no mural nodule or solid element, no abnormal doppler flow
      - >7cm probably still benign but treat as “complex”
    - Hemorrhagic (CL)
    - No need for sono f/u <5cm. Rpt sono > 5cm

Incidental ovarian cysts

- Premenopausal non functional (complex) cysts
  - The report should characterize the complexity
  - Benign appearance: Consider referal to Benign Gyn
    - Endometrioma
    - Dermoid
    - Cystadenoma
      - Multiloculated cyst with thin septations
  - Concern for malignancy: Refer to Gyn or GynOnc
    - Solid elements, thick, irregular septations, abnormal doppler flow
- 4th down: Refer to Gyn

Incidental ovarian cysts

- Postmenopausal Simple cysts
  - Same definition as premenopausal
  - <1cm: No mention in report or f/u needed
  - 1-7cm: F/u for stability then annually
  - >7cm: refer for surgical eval
- PM complex cysts : refer

- 4th down: Refer to Gyn

4mm Endometrial Echo

- Studies of PMB
  - If echo appropriately visualized and <4mm (initially 5mm), endometrial path on f/u surgery <1:900. Adequately excludes pathology and no further w/u needed
    - Goldstein S, Sonography in PMB. JUM 2012;31:333-336
- Doesn't mean:
  - >4mm is pathologic, just that ultrasound can't exclude it
  - >4mm in someone NOT bleeding is pathologic

4mm endometrial echo

- Incidentally found endometrial echo >4mm without bleeding
  - Adequate evaluation of the whole echo
  - Lack of endometrial fluid (concern for bleeding retained by cervical stenosis)
  - No abnormal Doppler flow or echo pattern
- Probable benign atrophic polyp/fibroid
  - Ferrazzi E, et al Am J OG 2009;200-235

- 4^{th} down: refer to Gyn

Screening mammogram

- Find breast cancer early
- Minimize harm from the procedure
- Maximize single screening visit
- Many organizations have weighed in on guidelines
  - USPSTF
    - Ann Int Med. 2016;164:279-96
  - American Cancer Soc: Cancer.org
    - JAMA. 2015;314[15]:1599-1614
  - ACOG.org

Screening mammogram

- USPSTF 2015
  - Start age 50
    Individualize age 40-50
  - Biannual
  - No guidance > 75yo
  - No guidance yet for 3D
- 4^{th} down: Start discussion at 40

- ACOG
  - Start age 40
  - Annual
- ACS
  - Optional age 40-44
  - Annual age 45-55
  - Biannual > 55yo
  - Continue while well

Genetic Testing

- Enhance risk based monitoring or therapy
- Now panel based instead of individual genes
- Breast Ca lifetime risk 1 in 8
  - Up to 85% w/ BRCA, etc mutation
- Ovary Ca lifetime risk 1 in 72
  - Up to 46% w/ BRCA, Lynch, etc
- Many mutations with various penetrance and cancer association

Genetic Testing

- In some ways no different than checking cholesterol due to a FH of heart disease
- Protected by HIPAA
- Most will be negative and covered by insurance
  - If negative, can reduce concern in family with cancer or known mutation
- If positive, many options available

Genetic Testing

- NCCN.org
- Any personal or family history of Ovarian Ca
- Personal history of Breast Ca:
  - <age 45, Ahkenazi Jewish descent, Triple negative <60yo, 2 primaries
- FH Breast Ca:
  - Known mutation, male, 3 or more listed cancers or FH of above
- 4th down: Offer testing

Annual Exam

- Screening
- Age specific
  - No screening pelvic exam, no pap <21yo
- Benefits of screens vs harms of procedures and incidental information or not excluding important disease
- http://links.lww.com/AOG/A677 (reproductive aged women), A675 (Adolescents), A678 (Mature women), A679 (Women > 64yo)

- 4th down: annual exam.


Thank you