Cases in Women's Health

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Disclosure

I have no financial interests or relationships to disclose.

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Objectives

- Explain options of evidence-based screening for substance use disorders
- Understand use of expedited partner therapy
- Discuss differential diagnosis of postmenopausal bleeding

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Case

26-year-old P1001 at 36 weeks presents to Labor and Delivery reporting contractions q 3-5 minutes and vaginal bleeding. On exam her cervix is 3 cm, there is more bleeding than expected for cervical change. The fetal heart tracing is overall reassuring and tocometry shows contractions every 1-2 minutes.

- PMH: Asthma, History of prior opioid use disorder
- OB Hx: SVD (baby in the NICU for NAS)
- PSH: no surgeries
- Meds: Albuterol as needed
- ALL: None
- Social: currently lives with her partner, she has custody of her older child. She uses tobacco and reports stopped methadone when she learned of her pregnancy

What Is Your Next Step in the Work Up for This Patient?

A. Stabilize the patient
B. Order urine drug screen
C. Obtain more history
D. Call social work consult due to history of opioid use
E. Notify anesthesia and move to the OR

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Urine Drug Screen

- Do not use as sole assessment of substance use/use disorder (ACOG, 2012).
  - Short detection window (substance dependent)
  - Might not capture binge or intermittent use
  - Rarely detects alcohol
  - Doesn't capture prescription opioids (without confirmation testing)
- Useful adjunct primarily for individuals in treatment.
- Ethical issues –patient needs to give consent prior to specimen collection.

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ACOG Screening Guidelines

Screening for substance use should be part of comprehensive obstetric care and should be done at the first prenatal visit in partnership with pregnant woman. Screening based only on factors, such as poor adherence to prenatal care or prior adverse pregnancy outcome, can lead to missed cases, and may add to stereotyping and stigma.

Early **universal screening, brief intervention** (such as engaging the patient in a short conversation, providing feedback and advice), and **referral for treatment (SBIRT)** of pregnant women with opioid use disorder improve maternal and infant outcomes.

Who can perform SBIRT? Physicians, nurse practitioners, physician assistants, nurses, health or substance use counselors, prevention specialists, and other health or behavioral health staff.

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Screening Instruments

- No single best screening instrument to identify pregnant women with substance use disorders.
- Self-administered or part of the patient interview.
- Developed for or validated in pregnant women:
  - 4P's Plus (Chasnoff, 1999)
  - TAPS (replaces NIDA quick screen)
  - CRAFFT (Chang, 2011) (women 26 years or younger)

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The 4 P's

1. Have you ever used drugs or alcohol during pregnancy?
2. Have you had a problem with drugs or alcohol in the past?
3. Does your partner have a problem with drugs or alcohol?
4. Do you consider one of your parents to be an addict or alcoholic?

***5 P's

5. Do any of your peers have problems with drugs or alcohol?

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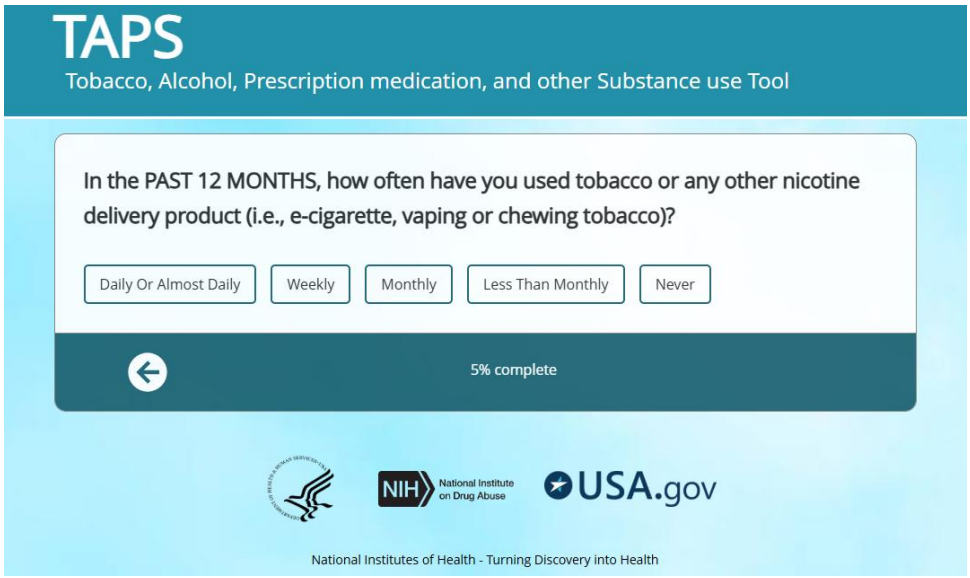
TAPS



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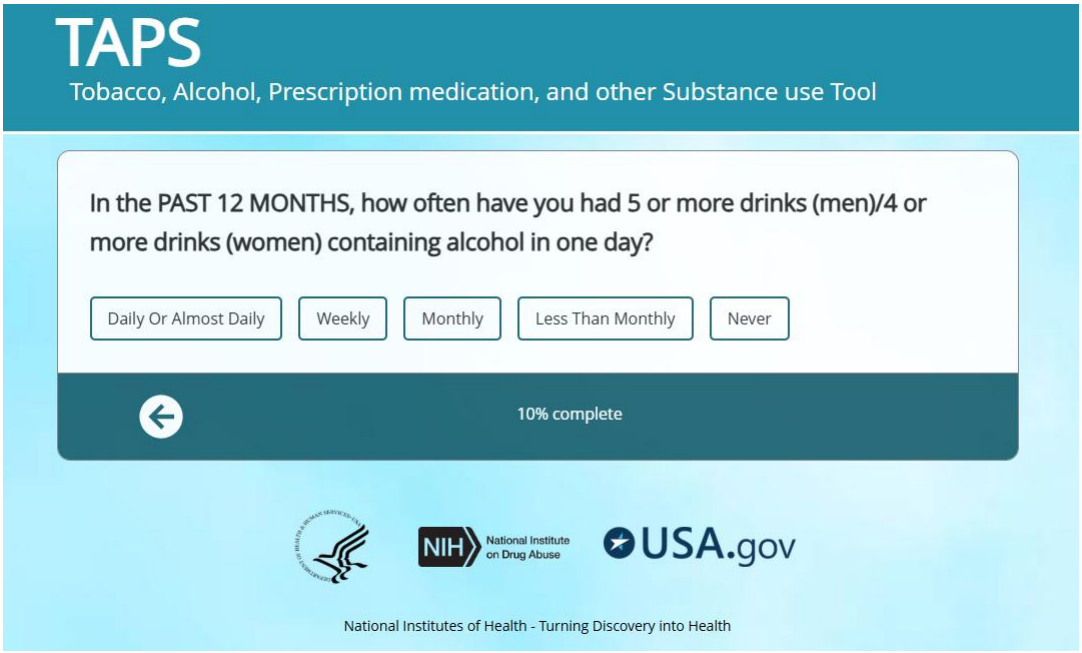
TAPS
Tobacco, Alcohol, Prescription medication, and other Substance use Tool
In the PAST 12 MONTHS, how often have you had 5 or more drinks (men)/4 or more drinks (women) containing alcohol in one day?
Daily Or Almost Daily
Weekly
Monthly
Less Than Monthly
Never
10% complete
NIH National Institute on Drug Abuse
USA.gov
National Institutes of Health - Turning Discovery into Health

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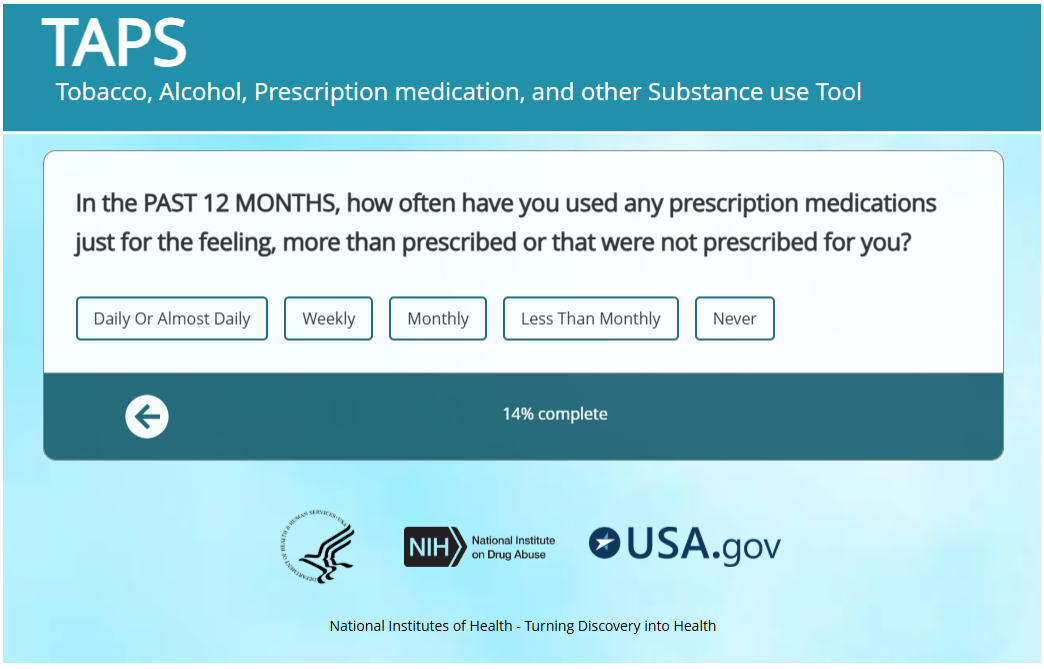
TAPS
Tobacco, Alcohol, Prescription medication, and other Substance use Tool
In the PAST 12 MONTHS, how often have you used any prescription medications just for the feeling, more than prescribed or that were not prescribed for you?
Daily Or Almost Daily
Weekly
Monthly
Less Than Monthly
Never
14% complete
NIH National Institute on Drug Abuse
USA.gov
National Institutes of Health - Turning Discovery into Health

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CRAFFT

Substance Abuse Screen for Adolescents and Young Adults

C	Have you ever ridden in a *car* driven by someone (including yourself) who was "high" or had been using alcohol or drugs?
R	Do you ever use alcohol or drugs to *relax*, feel better about yourself, or fit in?
A	Do you ever use alcohol or drugs while you are by yourself, *alone*?
F	Do you ever *forget* things you did while using alcohol or drugs?
F	Do your family or *friends* ever tell you that you should cut down on your drinking or drug use?
T	Have you ever gotten into *trouble* while you were using alcohol or drugs?

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Case Continued

- The fetal heart tracing worsens, and you are concerned for placental abruption, and you go to the OR for cesarean delivery.
- The delivery is complication by placental abruption, the fetal apgars are 7,7. Several minutes after delivery the neonate has a high-pitched cry and is irritable. The pediatricians suspect possible NAS, but you note that the UDS was negative.

What Could Be Causing the Symptoms?

A. False negative opioid result
B. Patient is using drug not captured by UDS
C. Patient switched the urine sample
D. Patient is using Xanax

Kratom

- Unregulated herbal supplement
  - Found in leaves of SE Asian plant, *Mitragyna speciose*
  - Has stimulatory (low dose) and analgesic effects (higher dose)
  - Mitragynine has agonist activity at mu receptor
    - Associated with dependence, withdrawal, toxicity
  - Side effects:
    - Agitation, tachycardia, drowsiness, vomiting, confusion, hepatotoxicity, seizure, withdrawal, hallucinations, respiratory depression, coma

Kratom

- Used by patients with OUD as an alternative for self-withdrawal treatment from opioids
- Sold on-line, smoke shops, gas stations
- Street names: ketum, thom, biak, thang
- Does not show up in UDS
- Currently unrestricted in US, but "drug of concern"
- Withdrawal symptoms similar to opioid
  - Treat withdrawal similar to opioid withdrawal

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Trichomoniasis Treatment

- Couple should use condoms until partner is treated
- Sexual partner should be treated
  - Expedited partner therapy
    - public health strategy that allows clinicians to treat the **sexual partners** of patients diagnosed with certain **sexually transmitted infections (STIs) without examining the partner first**.

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Case

56-year-old female presents to clinic with concerns of vaginal bleeding. She reports her last period was approximately 3 years ago. She reports bleeding ranged from spotting to a light period and lasted for 2 days. She is not sure but thinks there was a little bit of abdominal cramping on the first day.

- PMH: Obesity Class II, HTN
- Family Hx: maternal grandmother "girl parts cancer"
- PSH: appendectomy
- Meds: none
- All: NKDA

What Additional Information Would You Like?

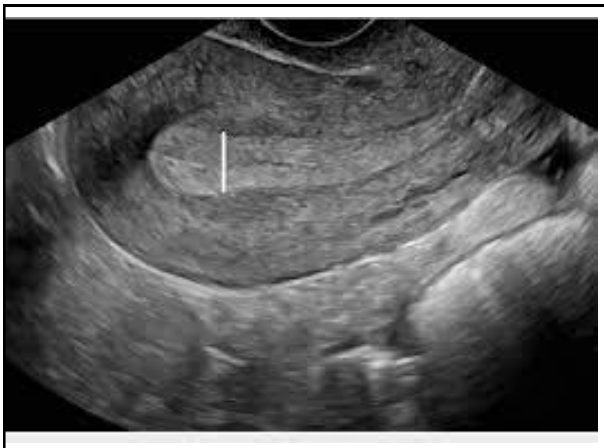
A. Patient BMI
B. Pelvic ultrasound
C. Endometrial biopsy
D. Sexual history
E. Pelvic exam findings

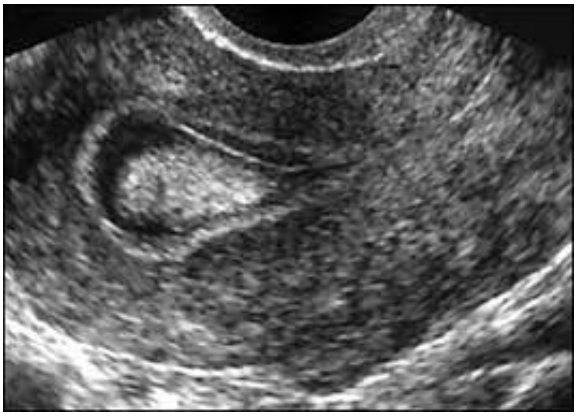
What Is Highest in Your Differential Diagnosis?

A. Endometrial cancer
B. Cervical cancer
C. Polyp (cervical, endometrial)
D. Atrophy
E. Vulvar cancer

Differential Diagnosis: Post-Menopausal Bleeding

- Endometrial cancer
  - On exam: If currently having symptoms may have bleeding from os
  - Work up includes: transvaginal ultrasound
    - Looking for endometrial echo to be 4mm or less (if thickened should refer to OBGYN)
      - If thickened endometrial echo may be related to:
        - Hyperplasia
        - Polyp
        - Fibroid
  - Endometrial biopsy
    - If you do not perform these, refer to OBGYN





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Differential Diagnosis: Post-Menopausal Bleeding

- Cervical Cancer
  - On exam: fungating mass or firm mass noted on cervix, may be friable to palpation with q-tip
  - If possible, perform pap smear (refer to OBGYN)
  - If possible, perform biopsy of lesion (or refer to OBGYN)

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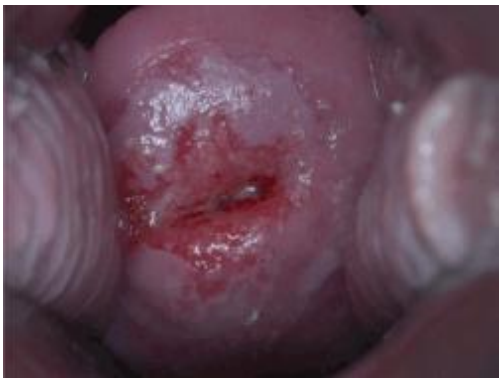
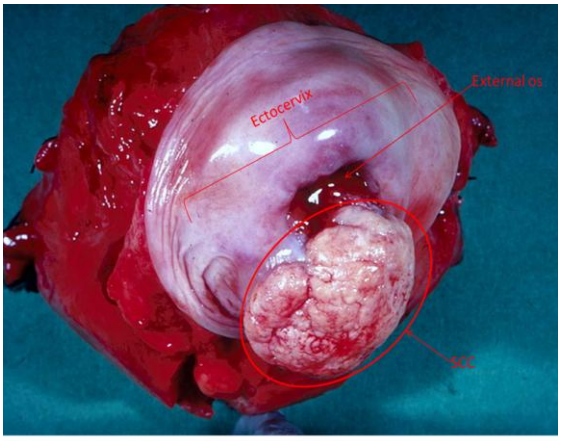


Image: wikipedia



Surgical excision of the cervix with a fungating squamous cell carcinoma

Eurocytology: Dharam M. Ramnani, MD, WebPathology.com)

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Differential Diagnosis: Post-Menopausal Bleeding

- Atrophy
  - On exam: thin/atrophic vaginal mucosa with lose of ruggae, possible abrasions
- Trauma
  - On exam: possible abrasions of the vaginal mucosa
- Cervical polyp
  - On exam: polypoid tissue at cervical os or within os
    - Can sample/excise or refer to OBGYN

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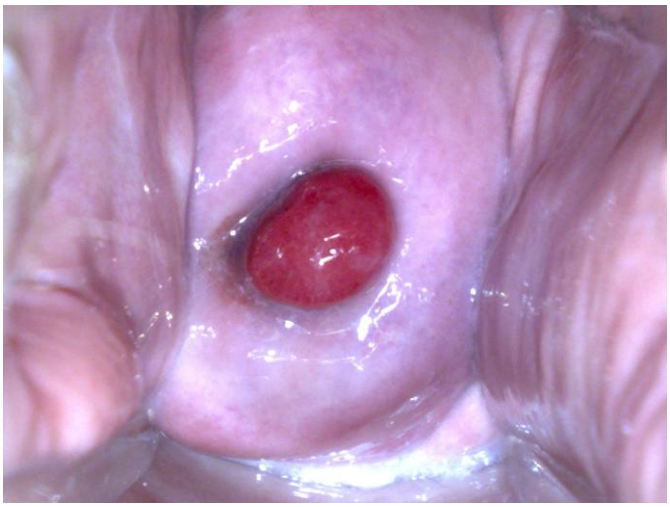

Image: Beautiful Cervix Project

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Case

- 18-year-old P0 presents to your office with concerns of heavy menstrual bleeding(HMB). She currently has monthly menses lasting 5-7 days with associated dysmenorrhea. She reports she previously used tampons and would frequently soak through them requiring a panty liner to prevent soiling her clothes. More recently she is using a menstrual cup and states on day 1-2 of her cycle she has to empty the cup every 2 hours or she soils her clothes. The HMB is interfering with her life and activities, and she is interested in treatment.
- What pharmacologic management are you considering offering this patient?

What Pharmacologic Management Are You Considering Offering This Patient?

A. Combined estrogen/progesterone treatment (pill, vaginal ring)
B. Progesterone only treatment (pill)
C. Hormonal Long-acting reversable contraceptive (LARC) ie IUD, Implant
D. Tranexamic Acid (TXA)
E. Non-hormonal LARC

What Additional Information Would Help Influence Your Selection Choice of Treatment?

A. Sexual Activity
B. Significant Medical history
C. Desire/Ability to take medications
D. History of prior medication treatment

Case Continued…

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- PMH: none
- PSH: none
- Meds: none
  - Previously used COC and became "very depressed"
- All: none
- Social: college student, not currently in a relationship

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Combined Estrogen-Progestin Contraceptives

- Pills, transdermal patch, vaginal ring
  - Inhibit midcycle surge of gonadotropin secretion
    - Suppress ovulation
  - Alter endometrial receptivity
  - Inhibit ability of sperm to access the upper genital tract

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Non-Contraceptive Benefits of Estrogen-Progestin Contraceptives

- Reduction in dysmenorrhea, menorrhagia
- Reduction in pelvic pain associated with endometriosis
- Reduction in risk of ectopic pregnancy
- Reduction in symptoms of PMS, PMDD
- Reduction in risk of benign breast disease, new ovarian cysts
- Reduction in risk of ovarian cancer, endometrial cancer, colorectal cancer
- Reduction in moderate acne, hirsutism

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Progestin Only Contraceptives

- Pill, injectable, implants
  - Thickening of cervical mucous which inhibits sperm penetration
  - Inhibit ovulation

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Progestin Only Contraceptives

- Desirable in the following populations
  - Migraine headache
  - Over 35 years old and smoker/obese
  - History of thromboembolic disease
  - Cardiac disease
  - Cerebrovascular disease
  - Early postpartum state
  - Hypertension with vascular disease over 35 years old
  - Hypertriglyceridemia

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Contraindications to Progestin Use

- Active breast cancer
- Severe decompensated cirrhosis
- Malignant liver tumor
- Past breast cancer
- Systemic lupus erythematosus with antiphospholipid antibodies

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LARC

Method	FDA Approval (yrs)	Effectiveness (yrs)
Implant	5	5
Progestin IUD	3,5,8	Up to 8
Copper IUD	10	12

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LARC

- Appropriate for adolescents and nulliparous women
  - Category 1 (Etonogestrel)
  - Category 2 (IUDs)

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LARC and Menstrual Cups

- First year expulsion rates 2-10%
  - Expulsion rates decrease after the first year
  - Some data to show (on internet-based surveys) that there is a 3-fold increase in expulsion rates in menstrual cup users
  - Important to counsel patients on this possibility
    - Consider to encourage them to perform more frequent string checks
    - In progesterone containing IUDs may be less of an issue as many women have decreased bleeding or amenorrhea
  - More data/research is needed

Contraception. 2024. Brown JE, Creinin MD, Wu H, et al.

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Tranexamic Acid

Mechanism of Action:

• Antifibrinolytic – inhibits conversion of plasminogen to plasmin

Clinical Effectiveness:

• Reduces menstrual blood loss by ~40–60%

• Improves quality of life in women with HMB

Dosing:

• 1,300 mg orally three times daily for up to 5 days during menses

Safety:

• Well tolerated; side effects include GI upset, headache

• No significant increased risk of thrombosis in otherwise healthy women

Clinical Role:

• Non-hormonal option

• Appropriate for women desiring fertility preservation

Tranexamic acid [package insert]. DailyMed, U.S. National Library of Medicine. FDA. Updated date: 2025-09-29.

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Cases

- 24-year-old female comes in for her 1st annual exam. She is very nervous, with poor eye-contact and she seems irritated when you ask her questions about her medical history. She says she came to get her 1st pap smear, but she has "changed her mind" and thinks she should just leave.
- A 42-year-old female comes to clinic as a new patient for an annual exam. You enter the room and she immediately states "I'm here for a doctor's appointment, not to fill out all these forms".
- 43-year-old female presents to clinic with concerns of foul vaginal discharge for the last 3 days. She has not been seen in 4 years due to prior lack of insurance. You review her history and state that you would like to proceed with a vaginal exam to assess her symptoms. She declines exam stating, "I don't like vaginal exams". How do you proceed?

How Do You Feel Reading These Cases?

A. "Just another day in clinic"
B. "Looks like this will be a short visit"
C. "Looks like this is going to take longer than the 20 min slot"
D. "I wonder what is going on with the person"

Realizing the Widespread Impact of Trauma

70% of US adults have had at least 1 traumatic experience in their lifetime

Psychological Medicine. 2015. Benjet C, Bromet E, Karam EG, et al.

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Realizing the Widespread Impact of Trauma

ACE Score Prevalence for CDC-Kaiser ACE Study Participants by Sex, Waves 1 and 2.

Number of Adverse Childhood Experiences (ACE Score)	Women Percent(N = 9,367)	Men Percent (N = 7,970)	Total Percent (N = 17,337)
0	34.5%	38.0%	36.1%
1	24.5%	27.9%	26.0%
2	15.5%	16.4%	15.9%
3	10.3%	8.5%	9.5%
4 or more	15.2%	9.2%	12.5%

Note: Research papers that use Wave 1 and/or Wave 2 data may contain slightly different prevalence estimates.
Source: Centers for Disease Control and Prevention, Kaiser Permanente. The ACE Study Survey Data [Unpublished Data]. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2016.

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What Is Trauma Informed Care (TIC)

- TIC acknowledges the widespread impact of trauma and aims to create environments that promote healing and avoid re-traumatization

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Best Practices for Screening

- Ask questions in a private and safe setting
- Sit at eye level, use active listening, be non-judgmental
- Offer psychoeducation explaining the effects of trauma on current health and health-related behaviors
- Allow for patient autonomy in collaborations with the patient on decisions about their treatment plan
- Avoid things that may increase anxiety or re-traumatization
- Encourage resilience- engage patient on the positive aspects of her life
- Include others for support- referrals to behavioral health

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Before the Exam

- Address the patient using name
- Speak clearly, slowly, and at an appropriate volume
- Check “your behaviors”
- Set an agenda
- Make it standard
- Identify concerns
- Ask about comfort
- Include a chaperone
- Employ active listening

Clardie S (2004)

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During the Exam

- Limit the number of people in the room
- Attend to draping and modesty
- Introduce exam components
- Explain why
- Ask permission
- Stay within eyesight
- Respect personal space
- Use simple, clinical language
- Check in
- Use professional touch
- Be efficient

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Draping and Modesty

Give	Give clear, specific instructions
Use	Use the words “gown” and “drape”
Offer	Offer multiple sizes of gowns
Allow	Allow the patient to move their own gown and/or drape when possible
Allow	Allow patients to wear clothing on body parts that are not being examined (e.g., lift shirt for abdominal exam)

Schachter et al (2009); Raja et al (2015)

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Draping and Modesty

- Privacy when undressing (may use curtain and/or door)
- Expose only the minimum body surface area required at any given time
- Do not assume that all men are comfortable baring a full chest
- Provide tissues as needed following a pelvic or rectal examination where lubrication is used
- Patient re-dresses privately once exam is finished
- Knock before re-entering the room, ensuring an affirmative patient response before opening the door (e.g., “all set”)

Schachter CL et al (2009)

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Simple, Clinical Language

- Easy to understand
- Avoids medical jargon
- Cautious with imagery; you never know what might be triggering
- Avoids all possible sexual connotation
- Minimizes power differential between patient and provider
- Accommodates patients who speak other languages
- Word choice is professional, not personal

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The Words We Choose Matter

Try to Avoid

- "bed"
- "that looks good"
- "feel"
- "look at"
- "push my fingers out"
- "relax"
- "take a deep breath"

Try to Use

- "exam table"
- "that looks healthy"
- "examine"
- "inspect"
- "bear down"
- "allow your legs to relax"
- "some people find it helpful to take some deep breaths during the exam"

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After the Exam

Express thanks

Discuss results

Ask for questions

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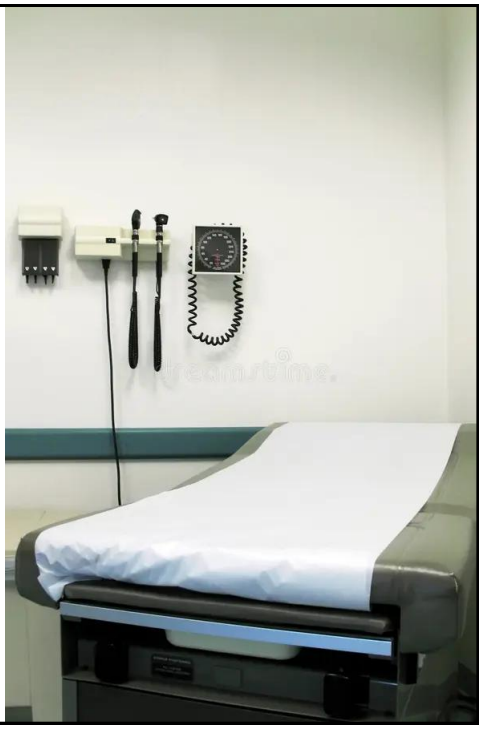
Tips to Remember About Your Patient Encounters

- The trauma may cause pts to seek healthcare: headache, stomachache, chronic pain
- When pts are triggered, it is hard for them to tell the MD what is going on
- Pts are counting on us to see the signs (dirty clothes, nails)
- Don't assume because wearing good clothes that everything is fine
- Those with hard childhood are good at hiding, trying to blend in, they may be embarrassed
- When they are stressed, their mind may go blank- wait, be present, let them know you see them…that you believe them
- Don't ask hard questions that don't have anything to do with the care they are getting



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Take Home Points

- Recognize some patients may be defensive, demanding, hard to engage
- Consider "I wonder what has *happened* to the patient to make them portray themselves in this way"… instead of "What's wrong with her?"
- Compassionate
- Patient-centered

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Sample Questions/Comments

"Is there anything I should know about your history before we get started?“

"Are you ready to change?“

"How are you doing?" or "Can we continue?“

“Some people find it helpful to talk with someone about their experiences, is that something you might be interested in?”

“Thank you for coming in today.”

“Thank you for helping me understand.”

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