Primary Care in Obstetrics and Gynecology

Second Edition

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A Handbook for Clinicians

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Preface

"The obligation to promote the good of the patients is a basic presumption of medical care giving a defining feature of the physician's ethical responsibility. To promote the patient's good is to provide care in which benefits outweigh burdens or harms" [American College of Obstetricians & Gynecologists (ACOG) Committee Opinion #156, 1995].

How does the busy clinician balance this with the conflicting pressures of time, regulation, paperwork, increased costs, declining reimbursements, burnout, and ever-changing knowledge? These issues have affected us at all levels: the medical student, the resident, and the established practitioner. This second edition of this book has been designed to address the issue of changing knowledge and to touch on some of the other issues as well.

Let us begin with medical student training. More information, clinical application, problem-based learning (PBLs), and oftentimes short but succinct obstetrics and gynecology rotations are the current name of the game. How can we train our future physicians to think multisystem? The ability to collate all information and apply it to the specific clinical problem at hand remains a challenge. One objective of this book is to tie the gynecologic and the medical knowledge clinical application together and to apply them to the patient who is currently in front of us.

Residency training continues to stress exposure to primary and preventive ambulatory health care, i.e., internal medicine, critical care, geriatrics, and the emergency department. The book is designed to provide information that can integrate these disparate callings.

Primary care, as obstetricians and gynecologists are asked to provide, covers the spectrum from the pediatric-adolescent, to the reproductive-aged woman, to menopause and beyond. Adolescent and sexual development and awareness, along with psychological and cognitive development, all begin early and proceed rapidly into adulthood. When should the first pelvic examination be performed? How do we provide health guidance and counseling based on age? We attempt to provide guidelines to these questions in this second edition.

Periodic health assessment is important in our day-to-day clinical activities. How do we as clinicians provide primary and preventive care? How does a busy clinician identify the high-risk patient? For example, when is a lipid profile or colorectal screening indicated? What is the gynecologist's role in preconception counseling and genetic testing, hepatitis vaccination, human immunodeficiency (HIV) assessment, mammography, influenza, and human papilloma virus vaccinations? The list goes on.

The second edition of this book is designed to provide a succinct, immediately clinically applicable source of information. It is our sincere hope that everyone who has this new revised edition at his or her disposal can provide excellence in clinical care.

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Section I

Primary Care and the Obstetrician-Gynecologist

1

Primary Care in Obstetrics and Gynecology: Health Maintenance and Screening

Douglas W. Laube

Background Information

Within a rapidly changing political and economic environment lies the fundamental need to provide continuity of patient care to decrease morbidity and mortality. Not all women need the same care and an attempt should be made by the clinician to focus on issues specific to high-risk categories and age-related variables (Tables 1.1–1.5). Additionally, scientific and economic documentation of the effectiveness of medical care has become an important issue in both clinical settings and policy-making situations. These concepts will also dictate physician reimbursement.

Periodic health maintenance implies the provision of health services generally considered to be part of primary care, but primary care must be differentiated from the confusing variety of other services, which are specialty specific. For example, "family care" would include a wide range of services to all family members regardless of age or sex and is characteristic of the practice of family medicine. "Comprehensive care" implies that all medical needs can be offered by a single provider, which is not a reasonable expectation. It is well recognized that all physicians who provide primary care services have limitations that depend on the content of their individual educational backgrounds and the scope of their subsequent practice experience. Periodic health maintenance for the gynecologist identifies a component of primary care that we can implement based on expertise acquired through our training as health care providers to women. Some of our health care provision may supersede issues of medical specialty, enabling us to provide for health maintenance and disease prevention.

Table 1.1. High-risk factors.

Intervention	High-risk factor
Bacteriuria testing	Diabetes mellitus
Colonoscopy	History of inflammatory bowel disease or colonic polyps; family history of familial polyposis coli, colorectal cancer, or cancer family syndrome
Fasting glucose test	Every 3–5 years for family history of diabetes mellitus (one first- or two second-degree relatives); marked obesity; history of gestational diabetes mellitus
Fluoride supplement	Live in area with inadequate water fluoridation (<0.7 ppm)
Genetic testing/ counseling	Exposure to teratogens; considering pregnancy at age 35 or older; patient, partner, or family member with history of genetic disorder or birth defect; African, Eastern European Jewish, Mediterranean, or Southeast Asian ancestry
Hemoglobin	Caribbean, Latin American, Asian, Mediterranean, or African ancestry; history of excessive menstrual flow
Hepatitis B vaccine	Intravenous drug use; current recipient of blood products; health-related job with exposure to blood or blood products; household or sexual contact with hepatitis B virus carriers; history of prostitution; history of sexual activity with multiple partners in last 6 months
Human immunodeficiency virus (HIV) testing	Seeking treatment for sexually transmissible diseases (STDs); drug use by injection; history of prostitution; past or present sexual partner who is HIV positive or bisexual or injects drugs; long-term residence or birth in an area with high prevalence of HIV infection; history of transfusion 1978 to 1985
Influenza vaccine	Resident in chronic care facility; chronic cardiopulmonary disorders; metabolic disease (e.g., diabetes mellitus, hemoglobinopathies, immunosuppression, or renal dysfunction)
Lipid profile	Elevated cholesterol level; history of parent or sibling with blood cholesterol of 240 mg/dl;

Table 1.1. ***Continued.***

Intervention	High-risk factor
	history of sibling, parent, or grandparent with documented premature (<55 years) coronary artery disease; diabetes mellitus or smoking habit
Mammography	Age 35 and older with premenopausally diagnosed breast cancer in a first-degree relative
Measles, mumps, rubella (MMR)	Childbearing age and no evidence of immunity; a second measles immunization, preferably measles, mumps, rubella (MMR) vaccine, if no proof of immunity
Pneumococcal vaccine	Factors for influenza vaccine plus sickle cell disease, Hodgkin's disease, asplenia, alcoholism, cirrhosis, or multiple myeloma
STD testing	History of multiple sexual partners or a sexual partner with multiple contacts, sexual contact with persons with culture-proven STD, history of repeated episodes of STD, attendance at clinics for STDs
Skin	Increased recreational or occupational exposure to sunlight; family or personal history of skin cancer; clinical evidence of precursor lesions
Thyroid-stimulating hormone	Strong family history of thyroid disease; autoimmune disease (evidence of subclinical hypothyroidism may be related to unfavorable lipid profiles)
Tuberculosis (TB) skin test	HIV infection; close contact with persons known or suspected to have tuberculosis (TB); medical risk factors known to increase risk of disease if infected; born in country with high TB prevalence; medically underserved; low income; alcoholism; intravenous drug use; resident of long-term care facility (e.g., correctional institutions, mental institutions, nursing homes and facilities); health professional working in high-risk health care facilities

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Table 1.2. Guidelines for women's health care: ages 13–18 years.

Screening
History
Reason for visit
Health status: medical, surgical, family
Dietary/nutritional assessment
Physical activity
Tobacco, alcohol, other drugs
Abuse/neglect
Sexual practices
Physical examination
Height
Weight
Blood pressure
Secondary sexual characteristics (Tanner staging)
Pelvic examination (yearly when sexually active or by age 18)
Skin[a]
Laboratory tests
Periodic
Pap test (yearly when sexually active or by age 18)
Cholesterol, high-density lipoprotein cholesterol (every 5 years)
High-risk groups[a]
Hemoglobin
Bacteriuria testing
Sexually transmitted disease testing
Human immunodeficiency virus (HIV) testing
Genetic testing/counseling
Rubella titer
Tuberculosis skin test
Lipid profile
Fasting glucose
Evaluation and counseling
Sexuality
Development
High-risk behaviors
Preventing unwanted/unintended pregnancy
Postponing sexual involvement
Contraceptive options

Table 1.2. ***Continued.***

Evaluation and counseling
Sexually transmitted diseases
Partner selection
Barrier protection
Fitness
Hygiene (including dental); fluoride supplementation
Dietary/nutritional assessment (including eating disorders)
Exercise: discussion of program
Psychosocial evaluation
Interpersonal/family relationships
Sexual identity
Personal goal development
Behavioral/learning disorders
Abuse/neglect
Cardiovascular risk factors
Family history
Hypertension
Dyslipidemia
Obesity
Diabetes mellitus
Health/risk behaviors
Injury prevention
Safety belts and helmets
Recreational hazards
Firearms
Hearing
Skin exposure to ultraviolet rays
Suicide: depressive symptoms
Tobacco, alcohol, other drugs
Immunizations
Periodic
Tetanus-diphtheria booster (once between ages 14 and 16)
High-risk groups[a]
Measles, mumps, rubella (MMR) vaccine
Hepatitis B vaccine

Continued.

Table 1.2. ***Continued.***

Leading causes of death
Motor vehicle accidents
Homicide
Suicide
Leukemia
Leading causes of morbidity
Nose, throat, and upper respiratory conditions
Viral, bacterial, and parasitic infections
Sexual abuse
Musculoskeletal and soft tissue injuries
Acute ear infections
Digestive system and acute urinary conditions

[a]See Table 1.1.
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Table 1.3. Guidelines for women's health care: ages 19–39 years.

Screening
History
Reason for visit
Health status: medical, surgical, family
Dietary/nutritional assessment
Physical activity
Tobacco, alcohol, other drugs
Abuse/neglect
Sexual practices
Physical examination
Height
Weight

Table 1.3. ***Continued.***

Screening
Blood pressure
Neck: adenopathy, thyroid
Breasts
Abdomen
Pelvic examination
Skin[a]
Laboratory tests
Periodic
Pap test (physician and patient discretion after three consecutive normal tests if low risk)
Cholesterol, high-density lipoprotein cholesterol (every 5 years)
High-risk groups[a]
Hemoglobin
Bacteriuria testing
Mammography
Fasting glucose test
Sexually transmitted disease testing
Human immunodeficiency virus (HIV) testing
Genetic testing/counseling
Rubella titer
Tuberculosis skin test
Lipid profile
Thyroid-stimulating hormone
Evaluation and counseling
Sexuality
High-risk behaviors
Contraceptive options
Genetic counseling
Prevention of unwanted pregnancy
Sexually transmitted disease
Partner selection
Barrier protection
Sexual function

Continued.

Table 1.3. ***Continued.***

Evaluation and counseling
Fitness
Hygiene (including dental)
Dietary/nutritional assessment
Exercise: discussion of program
Psychosocial evaluation
Interpersonal/family relationships
Domestic violence
Job satisfaction
Life-style/stress
Sleep disorders
Cardiovascular risk factors
Family history
Hypertension
Dyslipidemia
Obesity/diabetes mellitus
Life-style
Health/risk behaviors
Injury prevention
Safety belts and helmets
Occupational hazards
Recreational hazards
Firearms
Hearing
Breast self-examination
Skin exposure to ultraviolet rays
Suicide: depressive symptoms
Tobacco, alcohol, other drugs
Immunizations
Periodic
Tetanus–diphtheria booster (every 10 years)
High-risk groups[a]
Measles, mumps, rubella (MMR) vaccine
Hepatitis B vaccine
Influenza vaccine
Pneumococcal vaccine

Table 1.3. ***Continued.***

Leading causes of death
Motor vehicle accidents
Cardiovascular disease
Homicide
Acquired immunodeficiency syndrome (AIDS)
Cerebrovascular disease
Cancer
Leading causes of morbidity
Nose, throat, and upper respiratory conditions
Musculoskeletal and soft tissue including back and upper and lower extremities

[a] See Table 1.1.

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Table 1.4. Guidelines for women's health care: ages 40–64 years.

Screening
History
Reason for visit
Health status: medical, surgical, family
Dietary/nutritional assessment
Physical activity
Tobacco, alcohol, other drugs
Abuse/neglect
Sexual practices
Physical examination
Height
Weight
Blood pressure

Continued.

Table 1.4. ***Continued.***

Screening
Oral cavity
Neck: adenopathy, thyroid
Breasts, axillae
Abdomen
Pelvic and rectovaginal examination
Skin[a]
Laboratory tests
Periodic
Pap test (physician and patient discretion after three consecutive normal tests if low risk)
Mammography (every 1–2 years until age 50, yearly beginning at 50)
Cholesterol, high-density lipoprotein cholesterol (every 5 years)
Fecal occult blood test
Sigmoidoscopy (every 3–5 years after age 50)
High-Risk Groups[a]
Hemoglobin
Bacteriuria testing
Mammography
Fasting glucose test
Sexually transmitted disease testing
Human immunodeficiency virus (HIV) testing
Tuberculosis skin test
Lipid profile
Thyroid-stimulating hormone test
Colonoscopy
Evaluation and counseling
Sexuality
High-risk behaviors
Contraceptive options
Genetic counseling
Prevention of unwanted pregnancy

Table 1.4. ***Continued.***

Evaluation and counseling
Sexually transmitted disease
Partner selection
Barrier protection
Sexual functioning
Fitness
Hygiene (including dental)
Dietary/nutritional assessment
Exercise: discussion of program
Psychosocial evaluation
Family relationships
Domestic violence
Job/work satisfaction
Retirement planning
Life-style/stress
Sleep disorders
Cardiovascular risk factors
Family history
Hypertension
Dyslipidemia
Obesity/diabetes mellitus
Life-style
Health/risk behaviors
Hormone replacement therapy
Injury prevention
Safety belts and helmets
Occupational hazards
Recreational hazards
Sports involvement
Firearms
Hearing
Breast self-examination
Skin exposure to ultraviolet rays
Suicide: depressive symptoms
Tobacco, alcohol, other drugs

Continued.

Table 1.4. ***Continued.***

Immunizations
Periodic
Tetanus–diphtheria booster (every 10 years)
Influenza vaccine (annually beginning at age 55)
High-risk groups[a]
Measles, mumps, rubella (MMR) vaccine
Hepatitis B vaccine
Influenza vaccine
Pneumococcal vaccine
Leading causes of death
Coronary artery disease
Breast, lung, colorectal, and ovarian cancer
Cerebrovascular disease
Obstructive pulmonary disease
Leading causes of morbidity
Nose, throat, and upper respiratory conditions
Osteoporosis
Arthritis
Hypertension
Orthopedic deformities, including back and upper and lower extremities
Heart disease
Hearing and vision impairments

[a] See Table 1.1.

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Table 1.5. Guidelines for women's health care: age 65 years and older.

Screening
History
Reason for visit
Health status: medical, surgical, family
Dietary/nutritional assessment
Physical activity
Tobacco, alcohol, other drugs, concurrent medications
Abuse/neglect
Sexual practices
Physical examination
Height
Weight
Blood pressure
Oral cavity
Neck: adenopathy, thyroid
Breasts, axillae
Abdomen
Pelvic and rectovaginal examination
Skin[a]
Laboratory tests
Periodic
Pap test (physician and patient discretion after three consecutive normal tests)
Urinalysis/dipstick
Mammography
Cholesterol, high-density lipoprotein cholesterol (every 3–5 years)
Fecal occult blood test
Sigmoidoscopy (every 3–5 years)
Thyroid-stimulating hormone test (every 3–5 years)
High-risk groups[a]
Hemoglobin
Fasting glucose test
Sexually transmitted disease testing
Human immunodeficiency virus (HIV) testing
Tuberculosis skin test
Lipid profile

Continued.

Table 1.5. ***Continued.***

Evaluation and counseling
Sexuality
Sexual functioning
Sexual behaviors
Sexually transmitted diseases
Fitness
Hygiene (general and dental)
Dietary/nutritional assessment
Exercise: discussion of program
Psychosocial evaluation
Neglect/abuse
Life-style/stress
Depression/sleep disorders
Family relationships
Job/work/retirement satisfaction
Cardiovascular risk factors
Hypertension
Dyslipidemia
Obesity
Diabetes mellitus
Sedentary life-style
Health/risk behaviors
Hormone replacement therapy
Injury prevention
Safety belts and helmets
Occupational hazards
Recreational hazards
Firearms
Visual acuity/glaucoma
Hearing
Breast self-examination
Skin exposure to ultraviolet rays
Suicide: depressive symptoms
Tobacco, alcohol, other drugs

Table 1.5. ***Continued.***

Immunizations
Periodic
Tetanus–diphtheria booster (every 10 years)
Influenza vaccine (annually)
Pneumococcal vaccine (once)
High-risk groups[a]
Hepatitis B vaccine
Leading causes of death
Cardiovascular disease
Coronary artery disease
Cerebrovascular disease
Pneumonia/influenza
Obstructive lung disease
Colorectal, lung, and breast cancer
Accidents
Leading causes of morbidity
Nose, throat, and upper respiratory conditions
Osteoporosis
Arthritis
Hypertension
Urinary incontinence
Heart disease
Musculoskeletal and soft tissue injuries
Hearing and vision impairment
Colonoscopy

[a] See Table 1.1.

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The necessary provision of periodic health maintenance by the gynecologist should include all matters pertaining to the female reproductive system and nongynecologic care that may be related to disorders of the female reproductive system. For example, thyroid dysfunction, although not generally considered a gynecologic entity, may relate directly to an aberration in menstrual interval. Likewise, hypercholesterolemia and cholesterol metabolism are generally considered under the purview of other medical specialties. However, the relationship of cholesterol to hormone replacement in the menopausal patient gives it a higher priority in the gynecologist's periodic health care of women in appropriate age groups. Commonly included practices of gynecologic care such as cervical cytology, breast examination, and mammographic screening coupled with nongynecologic periodic health maintenance complete a wide range of services that can be timed according to individual need and age.

As the number of older women in the United States increases, the focus of women's health care must change as well. There will be less need for obstetric and surgical care and more demand for preventive health care. Additional surgical and obstetric training is less important for this most rapidly growing segment of society than a more comprehensive knowledge of matters relating to the morbidities of aging.

As the first proposals for health care reform were explained in 1993, the leadership of the American College of Obstetricians and Gynecologists (ACOG) was concerned that the proposed "gatekeeper" concept could undermine women's unrestricted, direct access to their obstetrician-gynecologist. It became clear that the only way to achieve this goal was to ensure that obstetrician-gynecologists are classified as primary care providers by insurance and managed-care entities. Survey data by the ACOG as well as data generated by the National Ambulatory Health Care Council suggest that both patients and practitioners view obstetrician-gynecologists as primary care physicians. This, coupled with the realization that the specialty has to accommodate to the managed care environment, has led to the only viable option of seeking designation as primary care providers.

It should be understood that there are many obstetrician-gynecologists both in the generalist ranks as well as subspecialists who do not want to function as primary care providers and who will not do so. Certainly this group of physicians should not provide primary care services and should be encouraged to function in the more traditional consultant role. However, a large number of obstetrician-gynecologists prefer the designation of primary care provider to preserve their patients' unrestricted access to care. Another aspect relative to the delivery of more broad-based health care services relates to the type and training of the health care practitioner. It is clear that the restructuring of health care financing and health care access using various managed care delivery systems is necessitating a reconsideration of our practice partners for the future. More consideration will be given in the future to physician collaboration with nonphysician health care providers for a variety of economically driven reasons. To provide comprehensive nongynecologic

health care, the obstetrician-gynecologist may benefit from employing nonphysician health care providers who can provide cost-effective primary care or expand management or clinical services not available within his or her own practice. This allows the obstetrician-gynecologist to gain access to a larger group of patients and to reduce the cost of providing existing services. The net effect is to stabilize revenue at a time when managed care reimbursement is shrinking per unit of service. Additionally, the obstetrician-gynecologist partners of the future may include physicians in other specialties, particularly family physicians and general internists. The ebb and flow of patient-related services in this type of arrangement is evident and potentially beneficial to all groups with the net effect of building a larger patient base. To accommodate to changes and provide appropriate educational foundations, a number of changes in the preparation of the provider for women's health care services will be necessary. It is anticipated that changes should begin early enough to provide the upper-level medical school undergraduate with the foundations for a more broad-based approach to women's health care/primary care.

The Association of Professors of Gynecology and Obstetrics (APGO) and the Council on Residency Education in Obstetrics and Gynecology (CREOG) are collaborating in designing a general fourth-year medical school curriculum to serve as a basis for guiding students interested in women's health care fields. It is thought that by focusing on these generally accepted areas, the future resident will already have sound educational underpinnings. Currently, funding limitations in many states are being discussed for medical schools that are not committed to the production of larger numbers of primary care providers. In the foreseeable future, limits will be imposed on the number of specialists and subspecialists that medical schools are able to train. Many states are considering legislation to mandate a higher percentage of primary care providers, offering funding only to the schools that are willing to meet this requirement.

Similarly, federal mandates will begin to change the number of residency positions through limits that are placed on monies allocated to hospitals to pay for postgraduate education. In addition, federal and state legislatures will probably increase their demands for larger numbers of nonphysician health care provider education. This will include physician assistants, advanced nurse-practitioners, and certified nurse-midwives as well as other allied health care professionals such as social workers and/or psychologists.

As the scope and responsibilities of the specialty change, so do the procedures and requirements by which physicians must be trained. An important aspect of the new special requirements promulgated by the Residency Review Committee in Obstetrics and Gynecology is to ensure that obstetrics and gynecology training programs respond to recent changes in medical practice. Under the new requirements, residency programs must provide training in primary and preventive care for at least 6 months of the 4-year residency. They must emphasize ambulatory care of patients, which includes both knowledge and skills in the areas of health maintenance, disease