Common OBGYN Problems in General Practice

Fatemah AlHadhoud

KBOG, MIGS

Senior Specialist in Obstetrics & Gynecology

Maternity Hospital

Kuwait

Objectives

1. Describe the most common OBGYN problems
2. Cervical Cancer Screening
3. Breast Cancer Screening

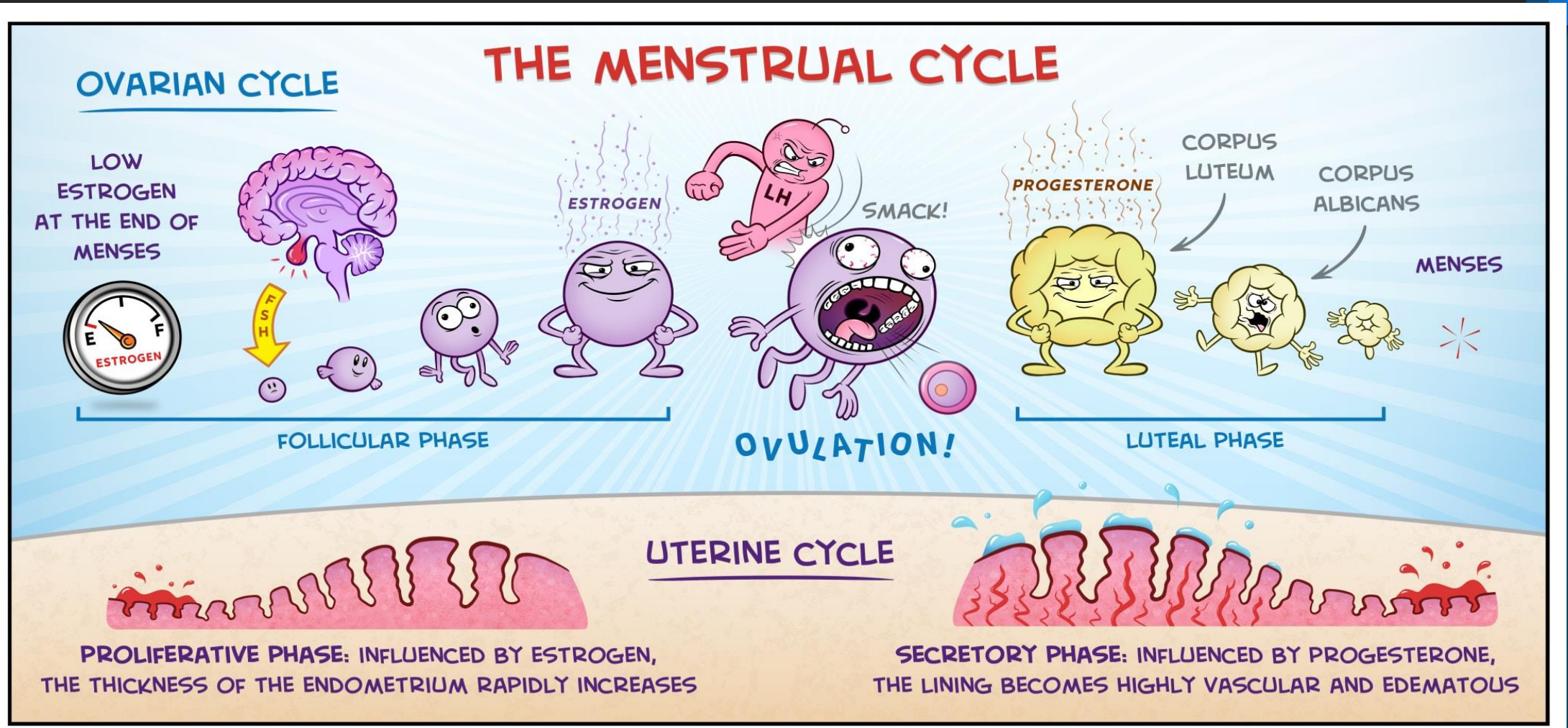
Abnormal Uterine Bleeding

Normal Uterine Bleeding

- Frequency: 24 – 38 days interval
- Duration: ≤ 8 days
- Regularity: variation ≤ 7 to 9 days
- Volume: 5 – 80 ml

Fraser IS, Munro MG, Broder M, Critchley HO, International recommendation on terminologies and definitions for normal and abnormal uterine bleeding. Semin Reprod Med 2011.

Normal physiology of Menstrual cycle



Abnormal Uterine Bleeding

- Bleeding from uterine corpus that is abnormal in regularity, volume, frequency or duration; and occurs in absence of pregnancy.

Older Definitions

- Menorrhagia: heavy menstrual bleeding
- Metrorrhagia: bleeding between periods – irregular intervals, excessive flow and duration.
- Plymenorrhea: bleeding that occurs more often than every 21 days
- Oligomenorrhea: bleeding that occurs at intervals longer than every 35 days.
- Amenorrhea: no menstruation. Primary (no menses by the age of 16 years) and Secondary(no menses for 3 months after menarche)
- Postmenopausal bleeding:

PALM-COEIN Classification of AUB

PALM = Visually objective structural criteria

- **P**olyp
- **A**denomyosis
- **L**eiomyoma
  - **S**ub**m**ucosal
  - **O**ther
- **M**alignancy & Hyperplasia

COEI = unrelated to anomalies
N = entities not yet structural classified

- **C**oagulopathy
- **O**vulatory Dysfunction
- **E**ndometrial
- **I**atrogenic
- **N**ot Yet Classified

Munro MG, et al. *Int J Gynaecol Obstet* 2011;113:3-13

How to manage a case of abnormal uterine bleeding?

Age → Cause → Treat

Common Differential by Age

13-18	19-39	40-Menopause
Endocrinologic • Immaturity of the HPO axis • PCOS • Thyroid disturbance Hematologic • VWD • Platelet Dx • Hemophilia • Clotting factor deficiency Pregnancy complication Pelvic infection/STD Trauma Tumor	Pregnancy Structural Lesions (leiomyoma, polyp) Anovulatory cycles (PCOS) Endometrial hyperplasia Malignancy (endometrial, cervical) Trauma Pelvic infection/STD	Anovulatory bleeding Endometrial hyperplasia/ carcinoma Cervical Ca Endometrial atrophy Leiomyoma Pregnancy Trauma Pelvic infection/STD

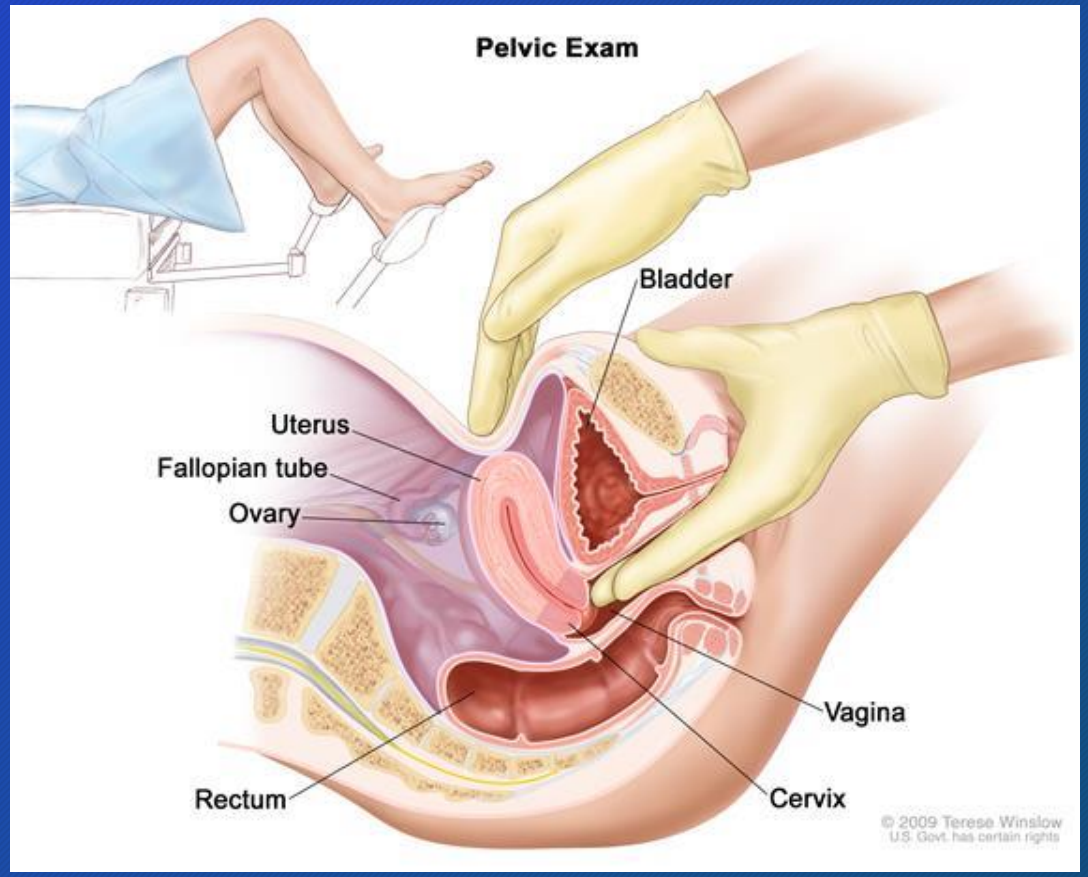
How to Approach Patient with AUB?

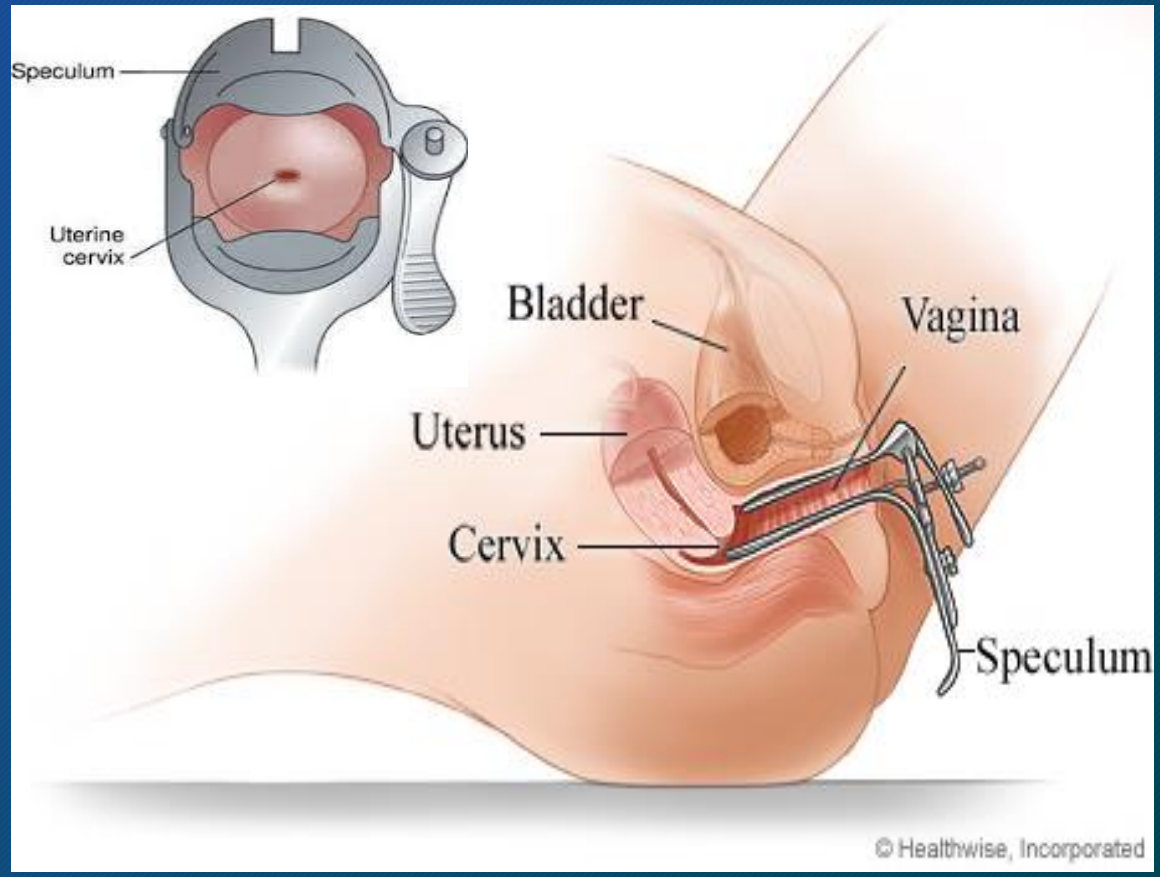
- History:
  - Focus on details of current bleeding episodes – length, duration, amount, presence of clots, and related symptoms like dizziness.
  - Past menstrual and gynecological history; Pap smears, recent hormonal therapy or surgery.
  - Medical history and medications: warfarin or heparin
  - Family history of bleeding disorders, VTE and malignancy
  - Look for DDx; cold/heat intolerance ?thyroid or weight loss and change in appetite

Physical examination

- Signs of acute blood loss, V/S and Anemia
- Findings suggesting of etiology!
- Confirm it is bleeding from genital tracts.
- Abdominal and pelvic examination, speculum and bimanual

Pelvic Exam


Pelvic Exam
Bladder
Uterus
Fallopian tube
Ovary
Vagina
Rectum
Cervix
© 2009 Terese Winslow
U.S. Govt. has certain rights

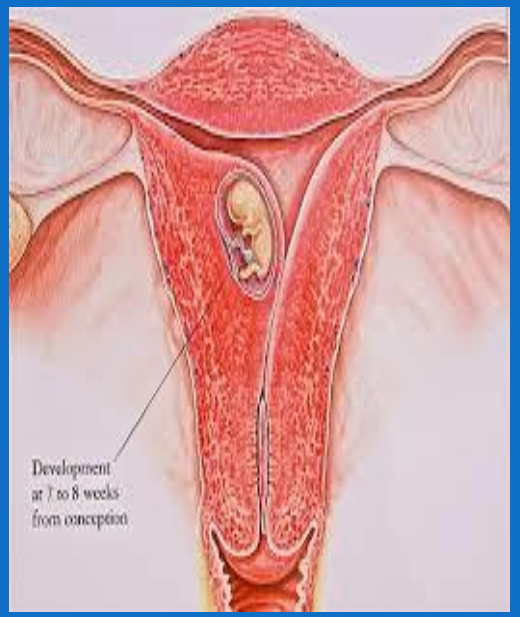

Speculum
Uterine cervix
Bladder
Vagina
Uterus
Cervix
Speculum
© Healthwise, Incorporated

Investigations

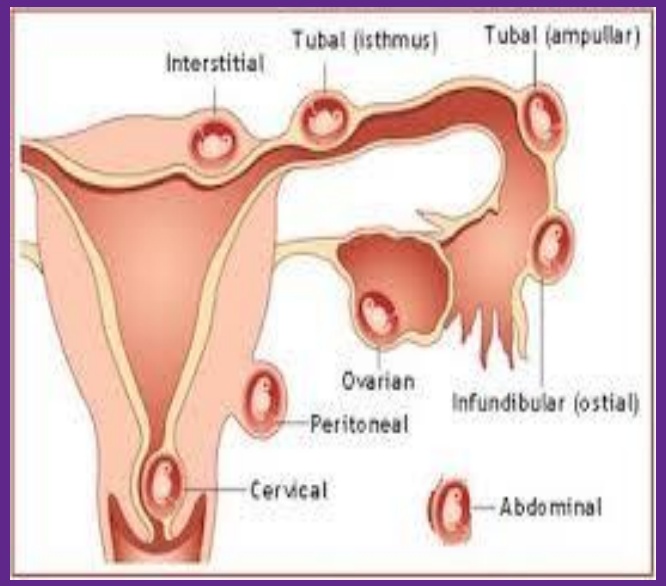
- Pregnancy test
- CBC, iron and ferritin

- Coagulation study; PTT/INR and vW-factor/factor VIII when indicated
- Hormonal; FSH/LH, TSH and prolactin
- Pap smear and cytology
- Endometrial biopsy

Pregnancy Test +



abortion



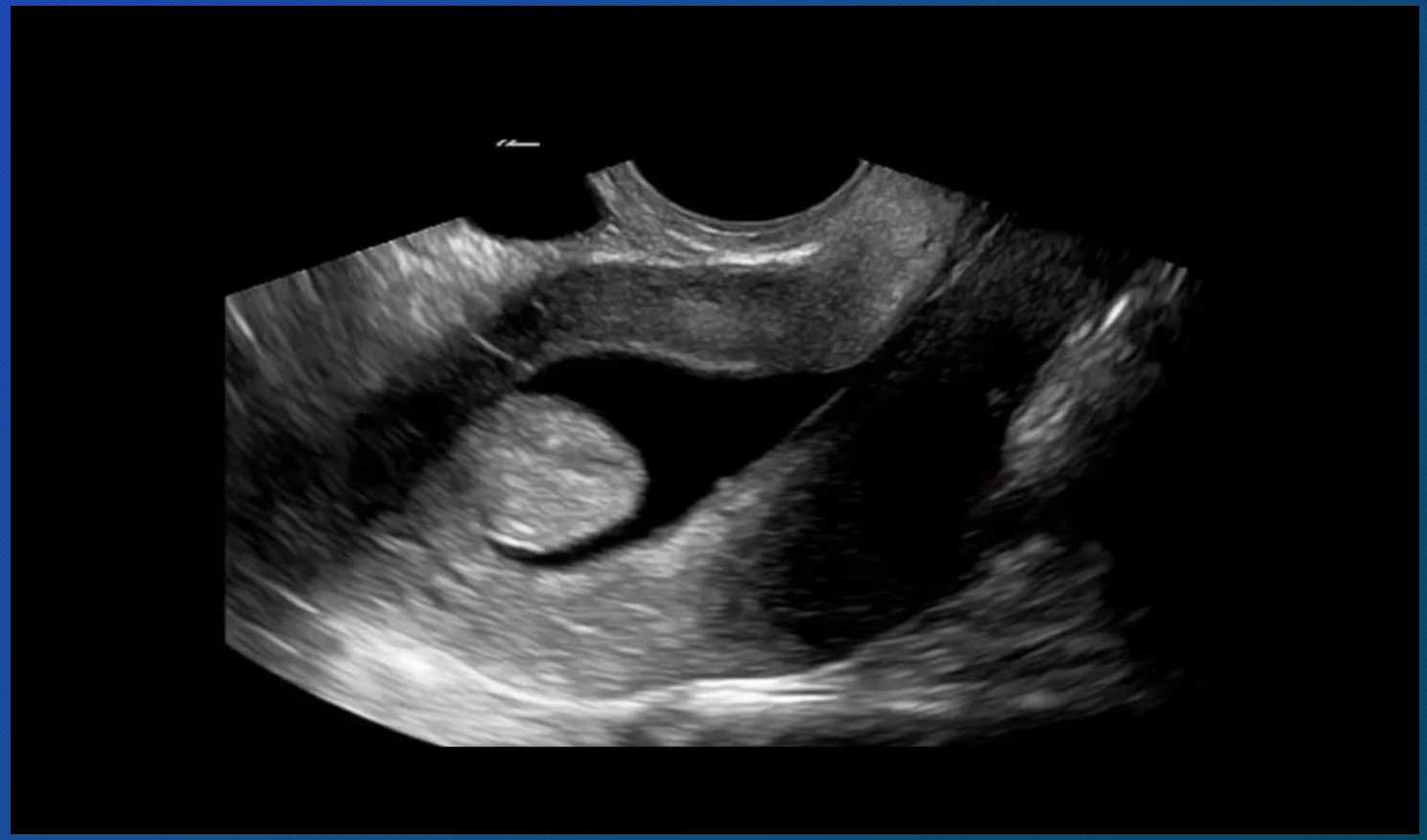
ectopic

Vesicular mole

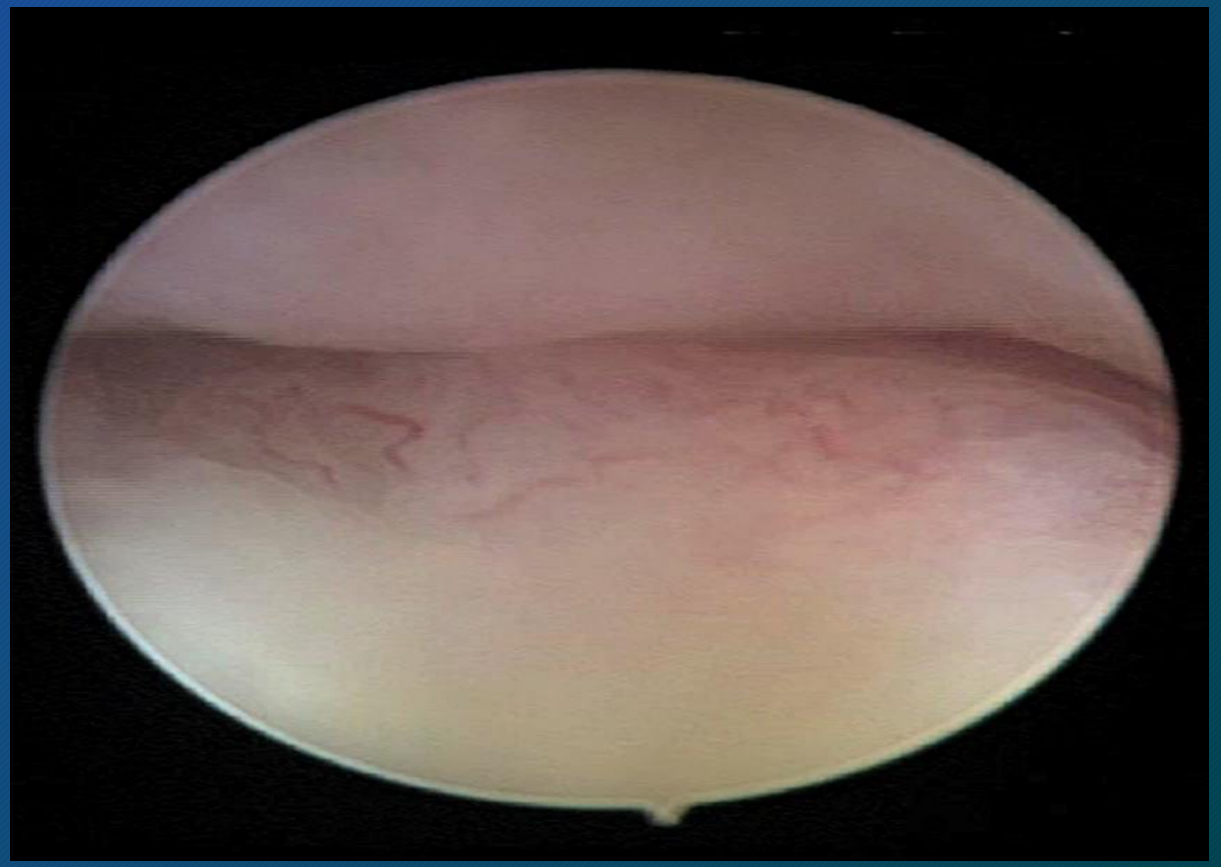
Imaging

- Pelvic Ultrasound; TVS
- Saline infusion sonohystrography (HyCoSy)
- Office hysteroscopy
- MRI

Saline infusion sonohystrography



Office hysteroscopy



Management

- Iron
- Stop or minimize uterine bleeding.
  - TA
  - Hormonal
- Refer for further evaluation and management.
  - ER according to stability of patient by Ambulance or by self.
  - Clinic

General Consideration

- Medical treatment should be initial treatment for most patients
- Need for surgery is based on various factors:
  - Stability of patient
  - Severity of bleed
  - Contraindications to medical treatment
  - Underlying cause
  - Desire for future fertility
- Long term maintenance therapy after acute bleed is considered.

Initial Approach

- Determine if AUB acute vs chronic
- If acute AUB, are there sign of hemodynamic instability/
- If yes, resuscitate
- IV access with 1 to 2 large bore cannula.
- Crystalloids vs colloids
- Prepare for blood transfusion
- Once stable, evaluate etiology (PALM-COEIN)
- Determine treatment.

Medical Treatment: Antifibrinolytics

- Reduce bleeding by 40-60%
- Tranexamic acid
- Work: prevent plasminogen activation and decrease fibrinolysis, so decreasing bleeding.

*Given in combination with NSAIDs; Cyclo-oxygenase inhibitors,

Mefanamic acid

NSAIDs act by reducing endometrial prostaglandin levels and promoting vasoconstriction in the uterus, leading to decreased blood loss.


Pfizer
PONSTAN®
500 mg
ACIDO MEFENÁMICO
Tabletas Recubiertas
VIA DE ADMINISTRACIÓN ORAL


5 mL Sterile/Stérile
Tranexamic Acid
Injection BP
500 mg/5 mL
100 mg/mL Tranexamic Acid
For intravenous use only
LATEX FREE/SANS LATEX
STERIMAX INC.


Tranexamic Acid
500mg Tablets
Tranexamic Acid PhEur
60 Tablets
MANX Pharma


NDC 0517-0960-10
Rx only
TRANEXAMIC ACID
INJECTION
1000 mg/10 mL (100 mg/mL)
FOR INTRAVENOUS USE ONLY
10 x 10 mL SINGLE DOSE VIALS
AMERICAN REGENT, INC.
NDC 0517-0960-01
TRANEXAMIC ACID
INJECTION
FOR INTRAVENOUS USE ONLY

Medical treatment: Hormonal

- **Treatment options:**
  - COC
  - Progesterone; MPA
  - Conjugated estrogen!!
  - Hormonal IUD; Mirena
  - GnRH analogue


yasmin
YAZ


Gynera
BAYER

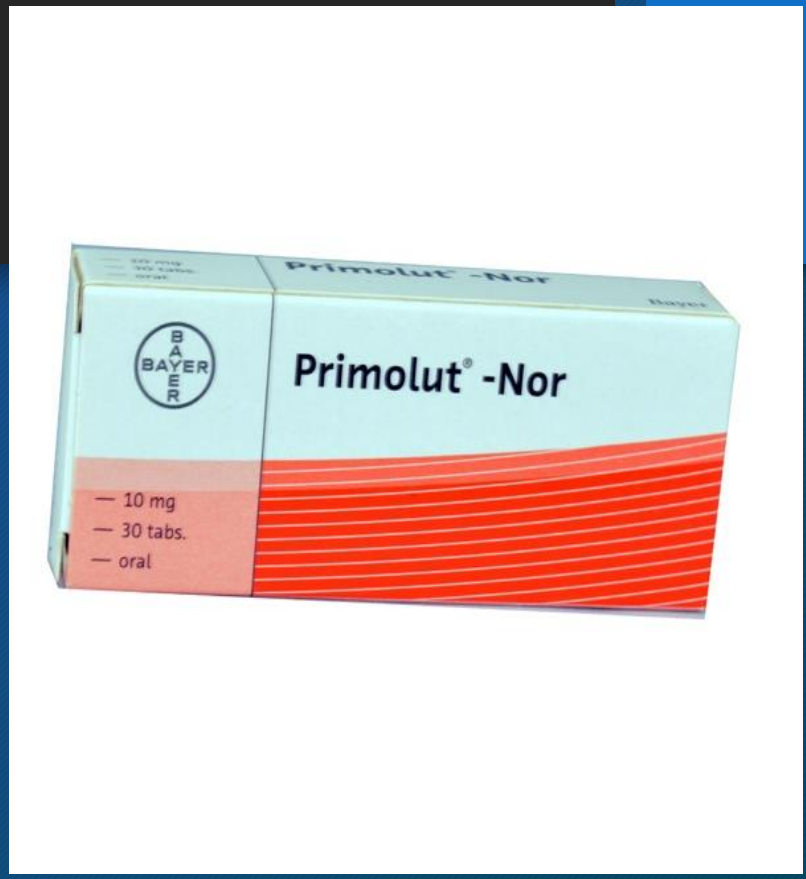

MSD
Marvelon
desogestrel/ethinylestradiol
3 x 21 tablets
CHILD RESISTANT PACK
TEAR HERE
MSD


PROVERA®
5mg
MEDROXYPROGESTERONI ACETAS
tablety
24 tablet
PERORÁLNÍ PODÁNÍ
PROVERA
5mg
24 tablet
PERORÁLNÍ PODÁNÍ

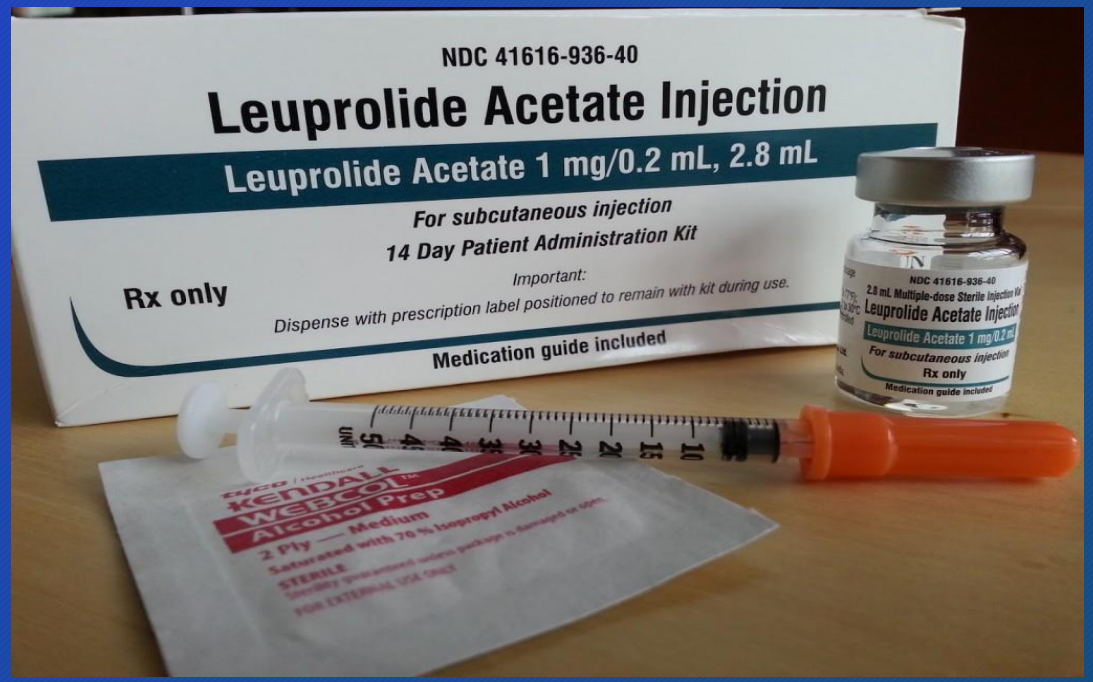

NDC 0009-0050-02
100 Tablets
Provera®
medroxyprogesterone
acetate tablets, USP
10 mg
Drug-Express
drugexp.jp

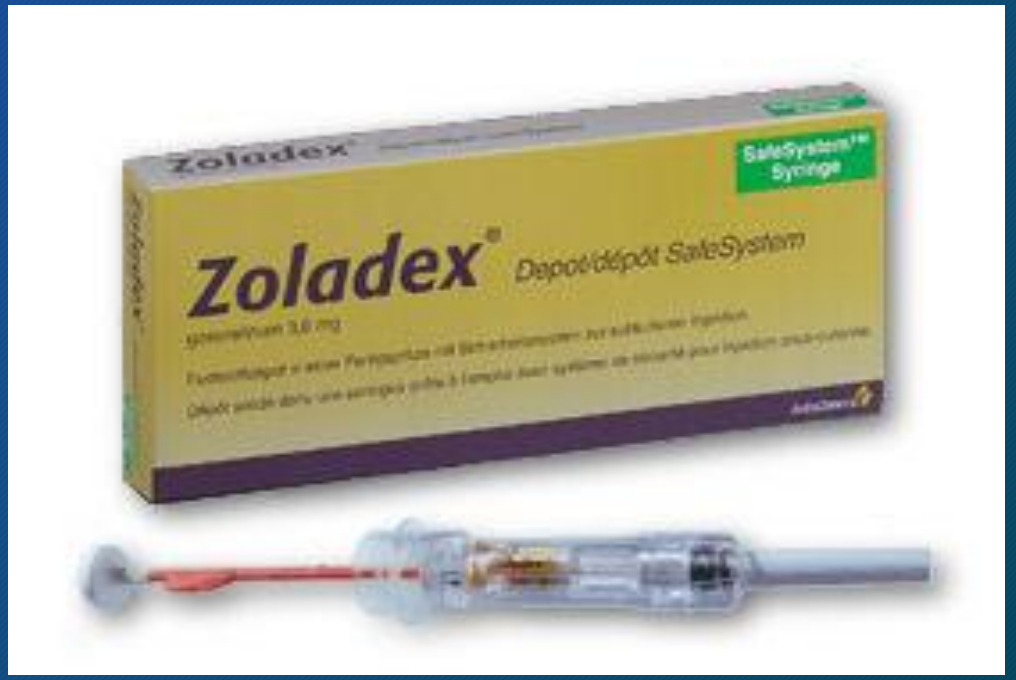

PRESCRIPTION ONLY MEDICINE
KEEP OUT OF REACH OF CHILDREN
Provera®
Tablets
5 mg
medroxyprogesterone acetate
www.inhousepharmacy.jp

- Norethisterone, which is a synthetic version of progesterone, 10mg
- 20-30mg for 14 days Or 20mg for 21 days



GnRH agonist





Pharmacologic Treatment Regimens For Acute Abnormal Uterine Bleeding

Drug	Dose
Hormonal treatments (conjugated equine estrogen)	25 mg IV every 4-6 h until 24 h bleeding stops
Combination oral contraceptive pills (monophasic oral contraceptive pills containing < 35 mcg ethinyl estradiol recommended)	1 pill tid PO for 7 days **or** 1 pill bid PO for 5 days, then 1 pill od until pack is finished
Progestin-only pills (medroxy- progesterone acetate)	20 mg tid PO for 7 days **or** 10 mg od PO for 10 days
NSAIDs: Mefenamic acid	500 mg tid PO for 4-5 days or until bleeding stops
Anti fibrinolytic agents (tranexamic acid)	500/1000mg tid IV/PO for up to 5 days

Summary

- Fe therapy
- Antifibrinolytics with NSAIDS
- COC
- Progestin
- GnRH analogue

Dysmenorrhea

Dysmenorrhea

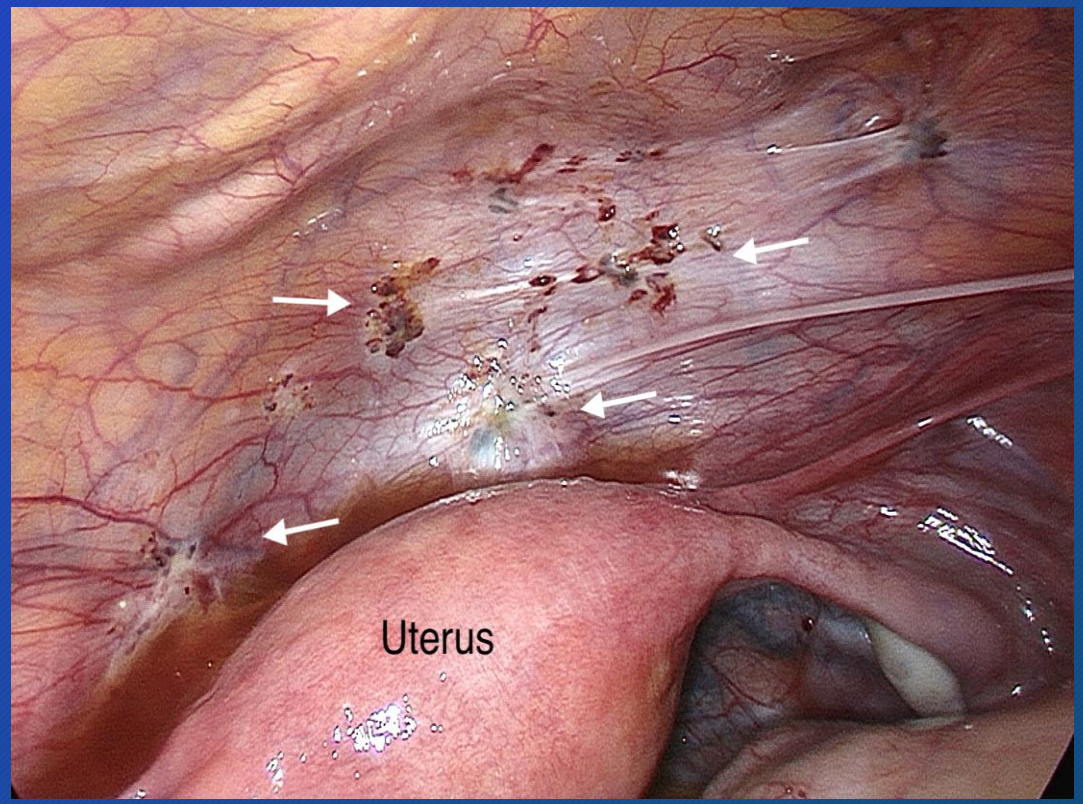
- Dysmenorrhea, or painful menstruation, is a common problem experienced by women in their reproductive years.
- Dysmenorrhea can be a primary process or secondary to other pelvic pathology.
- When severe, in addition to impairing quality of life, it interferes with the performance of daily activities, often leading to decreased productivity from school, work, and other responsibilities

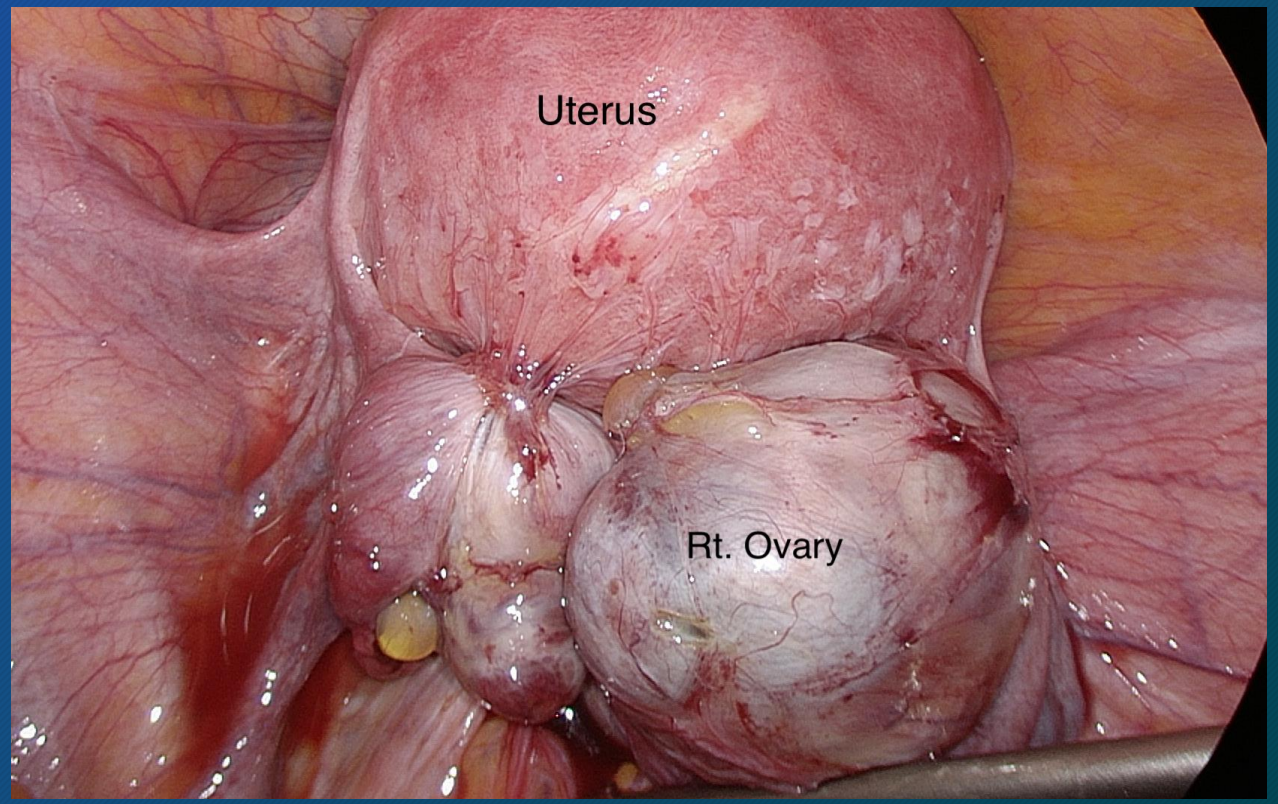
Dysmenorrhea

- **Primary dysmenorrhea** refers to the presence of recurrent, crampy, lower abdominal pain that occurs during menses in the absence of demonstrable disease that could account for these symptoms. The diagnosis of primary dysmenorrhea, which is one of **exclusion**, is made more often in **adolescents and young women.**

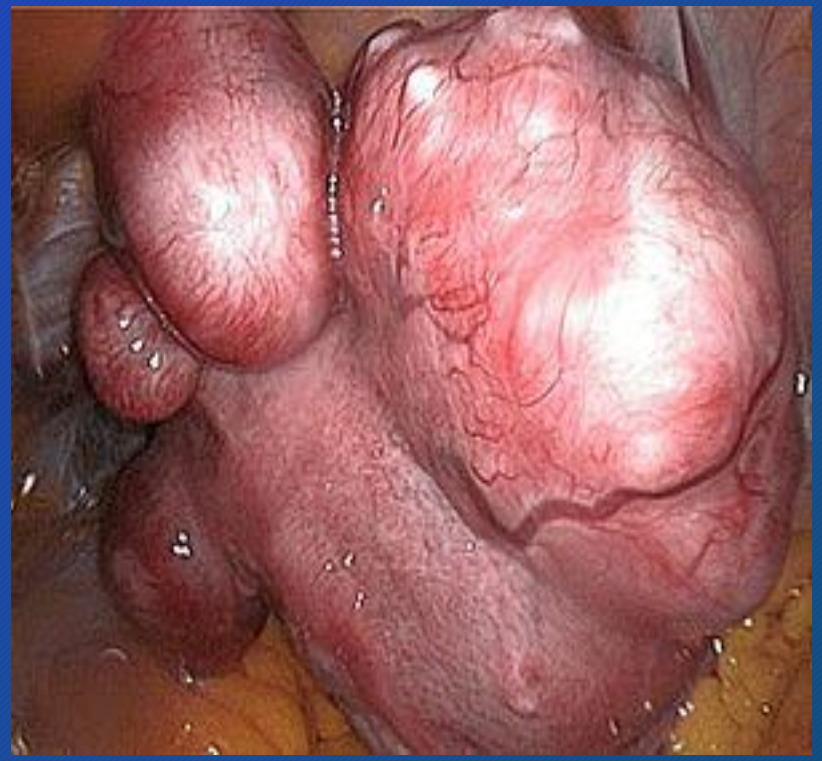
- **Secondary dysmenorrhea** has the same pain symptoms but occurs in women with a disorder that could account for their symptoms, such as endometriosis, adenomyosis, or uterine fibroids

Endometriosis

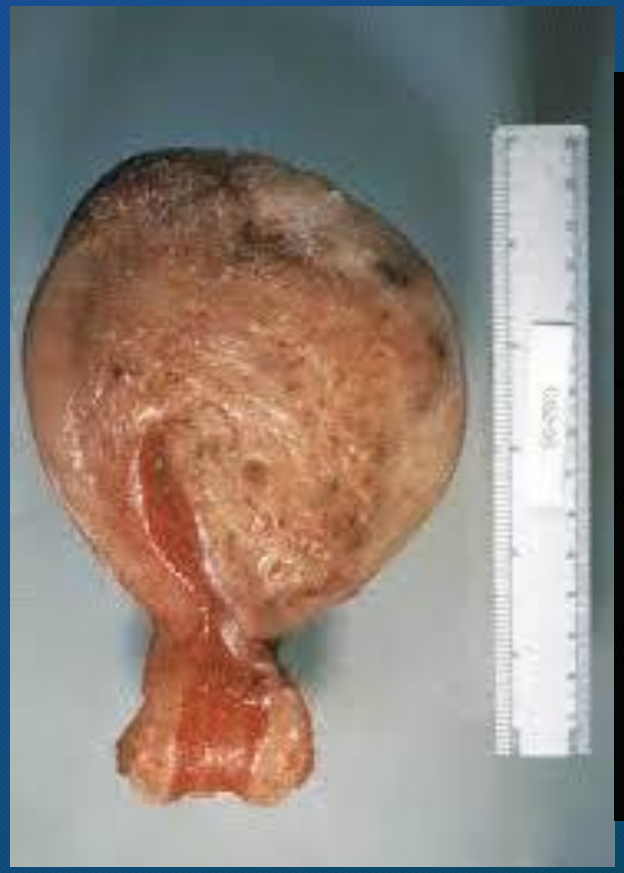


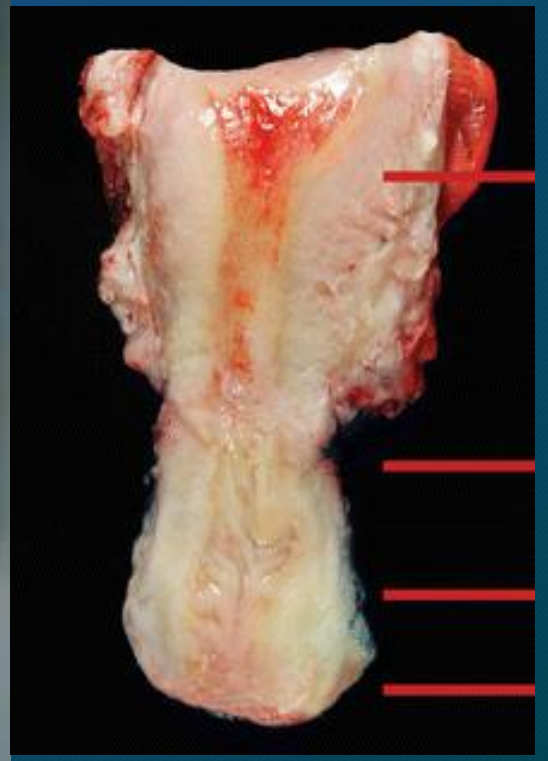


Fibroid Uterus



Adenomyosis





Treatment

- Analgesia: NSAIDs +/- Paracetamol
- Hormonal: COC, POP or Mirena IUD
- Not responding → laparoscopy

Vaginal Discharge

Normal

- In reproductive ages women, normal discharge cocsists of 1 to 4 ml fluid per 24 hours, white or transparent, thick or thin, and mostly odorless.
- It’s formed by mucoid endocervical secretions in combination with sloughing epithelial cells, normal flora and vaginal transudete.
- Its more noticeable at time of ovulation or during pregnancy or using COC.

- 90% of abnormal discharge is caused by infection, mainly:
- Bacterial vaginosis
- Candidiasis
- Trichomoniasis

- These 3 diagnosis should be excluded in all patients before considering other less common.

History

- New sexual partner/partner symptomatic.
- Use of new soaps or detergents
- Douching
- Contraceptive IUD use
- Symptoms such as abdominal/pelvic pain, itching, odor of discharge
- Fever
- Dysuria

Symptoms

Bacterial vaginosis	Candidiasis	Trichomoniasis
Approximately 50% asymptomatic	10–20% asymptomatic	10–50% asymptomatic
Offensive fishy-smelling discharge	Vulval itching	Offensive vaginal discharge
	Vulval soreness	Vulval itching/irritation
	Vaginal discharge (non-offensive)	Dysuria
	Superficial dyspareunia	Rarely low abdominal discomfort

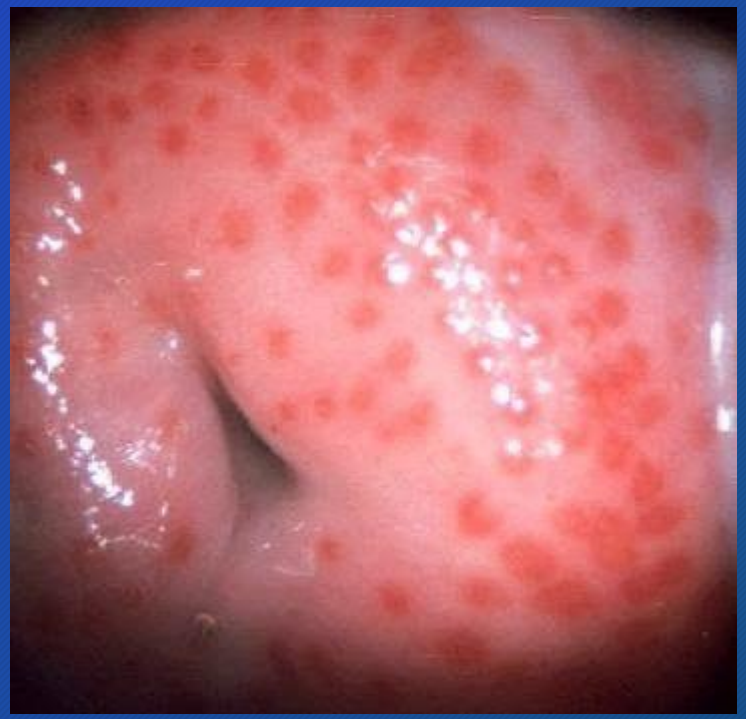
Physical Examination

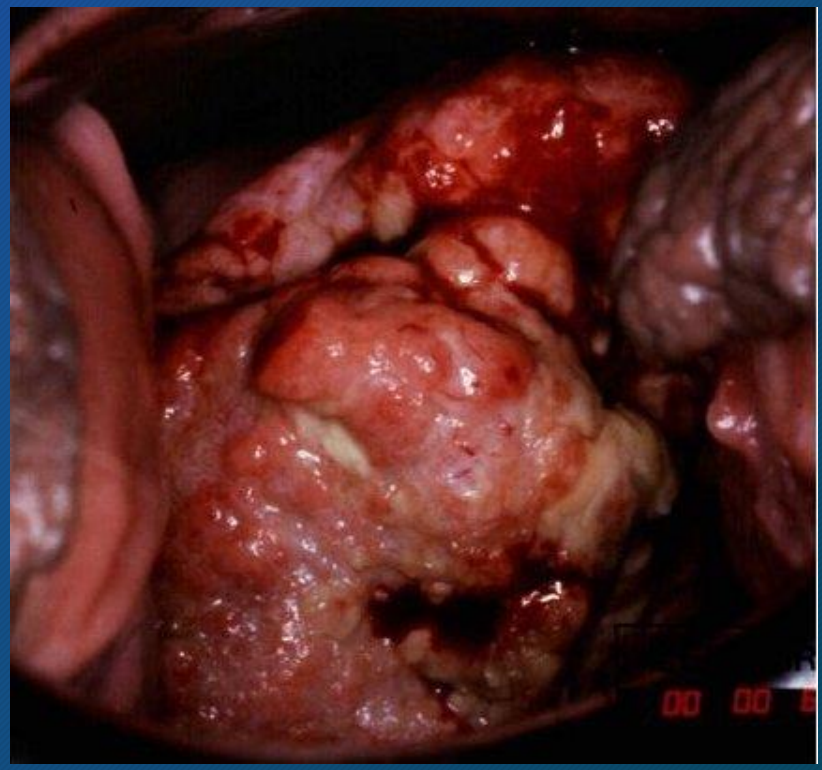
- The vulva appears normal in bacterial vaginosis
- Erythema, edema, or fissures suggest candidiasis, trichomoniasis, or dermatitis.
- Atrophic changes secondary to hypoestrogenemia suggest atrophic vaginitis.
- Foreign body with unpleasant odor and/or vaginal spotting.
- Vaginal warts can associated with discharge, pruritus, burning and pain.

Physical Examination

- Punctate hemorrhagic areas “strawberry cervix” is pathognomonic for trichomoniasis.
- Necrotic or inflammatory changes associated with malignancy result in vaginal odor discharge
- Bimaual examination to check for cervical motion tenderness or adnexal tenderness which suggest PID

Physical Examination





Physical Examination

Bacterial vaginosis	Candidiasis	Trichomoniasis
Thin white homogenous discharge, coating walls of vagina and vestibule	Vulval erythema	Vulval erythema
Absence of vaginitis	Vulval fissuring	Vaginitis
	Vaginal discharge may be curdy (non-offensive)	Vaginal discharge in up to 70%, frothy and yellow in 10–30%
	Satellite skin lesions	Approximately 2% 'strawberry' cervix visible to the naked eye
	Vulval oedema	5–15% no abnormal signs

Treatment of Candidiasis

- Clotrimazole 100mg vaginally tab HS for 6 -7 days
- Or Clotrimazole 500mg tab vaginally single dose.
- Clotrimazole 2% cream 5g intravaginally once daily for three days.
- Flucanazole 150mg orally once

- **For recurrent Dx:** fluconazole 150mg orally once daily every third day for 3 doses, then maintenance regimen of fluconazole 150mg once weekly for 6 months.
- Pregnancy: any **topical azole** vaginally once daily for 6-7 days.

Treatment of Bacterial Vaginosis

- Metronidazole 400mg orally twice daily for 7 days
- Clindamycin vaginal ovule 100mg once daily for 3-7 days
- Clindamycin vaginal cream 2% 5g once daily for 7 days

- Pregnancy:
  - Metronidazole all Trimesters
  - Clindamycin in T2 & 3.

Treatment of Trichomoniasis

- Metronidazole 400mg orally twice daily for 7 days
- Partner same treatment
- Avoid sexual intercourse until both have completed treatment and are asymptomatic.

- Candidiasis is not a sexually transmitted disease.
- Bacterial vaginosis is not a sexually transmitted infection.
- Trichomoniasis: sexual partners should be treated simultaneously.
- Any women with new or multiple sexual partners, symptomatic sexual partner, or unexplained cervical or vaginal discharge should be tested for other sexual transmitted infections; Chlamydia and Gonorrhea.
- Chlamydia & Gonorrhea: partner should be treated.

Chlamydia

- Mucopurulent dischartge
- Associated with dysuria and lower abdominal discomfort.
- Cultures must include urethral and cervical swabs

- Treatment:
- Azithromycin 1gm single dose
- Or
- Doxycycline 100mg BID for 7 days.

Gonorrhea

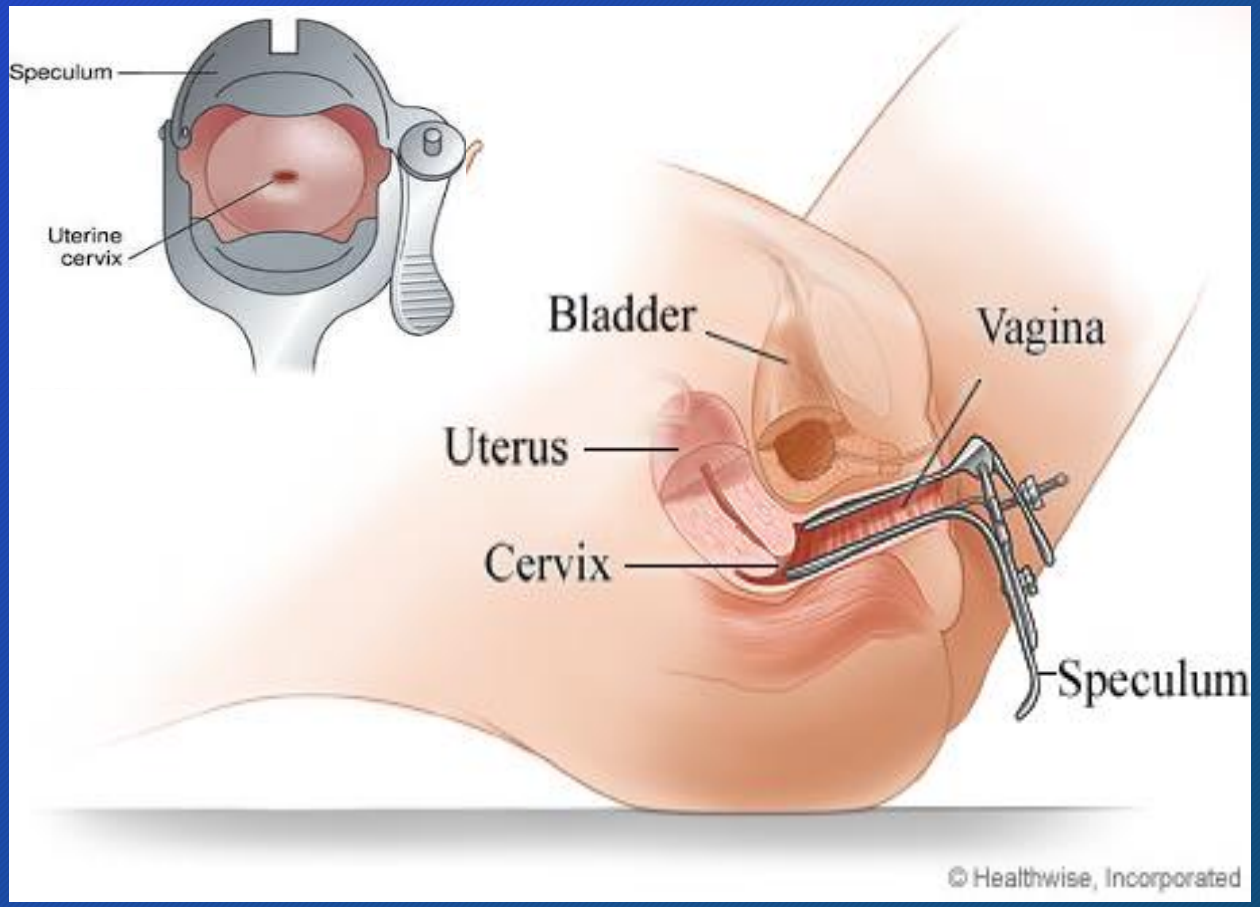
- Vaginal discharge and dysparunia

- Treatment:
- Cephalosporin; ceftriaxone 125mg IM
- Plus doxycycline
- Treat along with chlamydia as they coexist

Screening

Cervical Cancer Screening

- Two screening tests can help prevent cervical cancer or find it early
  1. The Pap test (or Pap smear) looks for *precancers*, cell changes on the cervix that might become cervical cancer if they are not treated appropriately.
  2. The HPV test looks for the virus (human papillomavirus) that can cause these cell changes.


Speculum
Uterine cervix
Bladder
Vagina
Uterus
Cervix
Speculum
© Healthwise, Incorporated

Cervical cancer Screening

- **Cervical cancer screening should start at age 21.**
- **People between the ages of 21 to 29** should get a Pap test every 3 years.
- **People between the ages of 30 to 65 have 3 options of testing.**
  - primary HPV (human papillomavirus) test done every 5 years.
  - Co-test (an HPV test with a Pap test) every 5 years or
  - Pap test every 3 years.
- ***The most important thing to remember is to get screened regularly, no matter which test you get.***

- **People over age 65** who have had regular cervical cancer testing in the past 10 years with normal results should not be tested for cervical cancer. Once testing is stopped, it should not be started again. Those with a history of a serious cervical pre-cancer should continue to be tested for at least 25 years after that diagnosis, even if testing goes past age 65.
- **People who have been vaccinated against HPV** should still follow the screening recommendations for their age groups.

Routine Cervical Cancer Screening

USPSTF Recommendations for Routine Cervical Cancer Screening

Population*	Recommendation	USPSTF Recommendation Grade†
Aged less than 21 years	No screening	D
Aged 21–29 years	Cytology alone every 3 years‡	A
Aged 30–65 years	Any one of the following: • Cytology alone every 3 years • FDA-approved primary hrHPV testing alone every 5 years • Cotesting (hrHPV testing and cytology) every 5 years	A
Aged greater than 65 years	No screening after adequate negative prior screening results§	D
Hysterectomy with removal of the cervix	No screening in individuals who do not have a history of high-grade cervical precancerous lesions or cervical cancer	D

Breast cancer Screening

- Checking a woman’s breasts for cancer before there are signs or symptoms of the disease. All women need to be informed by their health care provider about the best screening options for them.
- Although breast cancer screening cannot prevent breast cancer, it can help find breast cancer early, when it is easier to treat.
- Breast Cancer Screening Tests

1. Mammogram
2. Breast Magnetic Resonance Imaging (MRI)

Breast cancer Screening

- **Women ages 40 to 44** should have the choice to start annual breast cancer screening with mammograms (x-rays of the breast) if they wish to do so.
- **Women age 45 to 54** should get mammograms every 1-2 years.
- **Women 55 and older** should switch to mammograms every 2 years, or can continue yearly screening.
- Screening should continue as long as a woman is in good health and is expected to live 10 more years or longer.

Women at High Risk

- Some women – because of their family history, a genetic tendency, or certain other factors – should be screened with MRIs (US Breast <40 years) along with mammograms.
- In comparison, women with an abnormal *BRCA1* gene have a 50% to 70% risk of developing breast cancer by age 70.
- Women with an abnormal *BRCA2* gene have a 40% to 60% risk of developing breast cancer by age 70.

Breast Exam

Clinical Breast Exam

- A *clinical breast exam* is an examination by a doctor or nurse, who uses his or her hands to feel for lumps or other changes.

Breast Self-Awareness

- Being familiar with how your breasts look and feel can help you notice symptoms such as lumps, pain, or changes in size that may be of concern. These could include changes found during a *breast self-exam*.

Referrence

- Munro MG, et al. *Int J Gynaecol Obstet* 2011;113:3-13
- NICE guideline [NG88] Heavy menstrual bleeding: assessment and management. National Institute for Health and Care Excellence. March 2020https://www.nice.org.uk/guidance/ng88/chapter/Recommendations#management-of-hmb (Accessed on April 01, 2020).
- Berek's and Novak's Gynecology, 15th Edition. 2012.
- Committee opinion no.557: management of acute abnormal uterine bleeding in non pregnant reproductive-aged womwen. Obstet Gynecol. 2013 Apr; 121 (4): 891-6.
- Vaginal Discharhe: an approach to diagnosis and management, William J. Watson, MD, CCFP Gregory DeMarchi, MD, CCFp
- Vercellini et al. The effect of surgery for symptomatic endometriosis: the other side of the story. Human Repro Update Vol 15, No. 2, 2009.
- Oeffinger KC, Fontham ET, Etzioni R, Herzig A, Michaelson JS, Shih YC, Walter LC, Church TR, Flowers CR, LaMonte SJ, Wolf AM, DeSantis C, Lortet-Tieulent J, Andrews K, Manassaram-Baptiste D, Saslow D, Smith RA, Brawley OW, Wender R; American Cancer Society. Breast cancer screening for women at average risk: 2015 guideline update from the American Cancer Society. JAMA 2015;314(15):1599–1614.
- Committee on Practice Bulletins–Gynecology. Practice bulletin number 179: Breast cancer risk assessment and screening in average-risk women. Obstetrics and Gynecology 2017;130(1):e1–e16.
- Saslow D, Solomon D, Lawson HW, Killackey M, Kulasingam SL, Cain J, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. Am J Clin Pathol 2012;137:516–42. Available at: https://academic.oup.com/ajcp/article/137/4/516/1760450. Retrieved April 12, 2021. and ACOG *Practice Bulletin No. 168, October 2016.*

Thank You