Western Regional Urgent Care Conference

Common GYN Issues in an UC Setting

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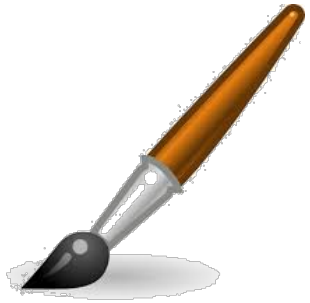
Objectives:

- Learn about the most common GYN reasons for visits to Urgent Care centers.
- Discuss the diagnostics that are needed
- Discuss the various approaches to treatment
- Discuss appropriate follow up

Little bit about me!

- Physician, entrepreneur
- Dedicated my life to Women's education and empowerment
- Presidential Leadership Scholar
- Holistic approach is key
- Sexual Health expert
- Exercise freak
- Risk taker and control freak
- Painter of the heart



Women..

- Are nearly half of the population.
- The female reproductive system is a constantly changing and adapting machine
- More reasons for things to break down
- Are busy juggling multiple hats so their own health struggles take a back seat
- Lack of immediate access to Women's health care

Most commonly encountered GYN conditions

- Pain
- AUB
- Vaginal infections
- Early pregnancy
- UTI
- STIs

{Insert pain pic and slide}

1. PELVIC PAIN

- Pain is one of the top causes of visits to an Urgent care, especially in women.
- Evaluation of pain in women can be intimidating.
- If we use a systematic approach, we can narrow the causes and get our patient the right care.

What the mind does not know, the eyes do not see!!

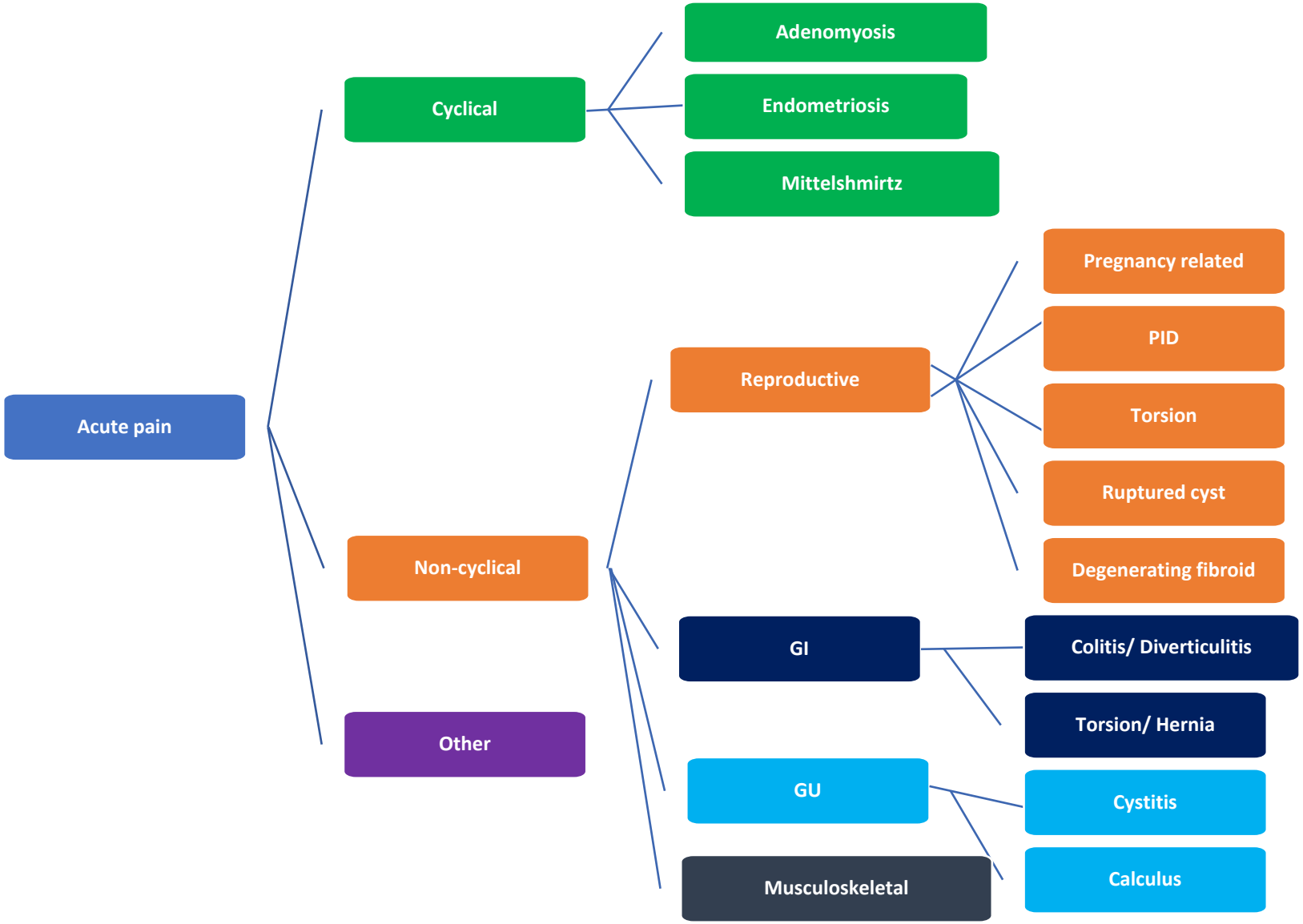
Pain – definition and types

- Acute: lower abdominal or pelvic pain that has lasted less than three months.
- Chronic: non-cyclic pain perceived to be in the pelvic area that has persisted for three to six months or longer and is unrelated to pregnancy

Over one-third of reproductive-aged women will experience non-menstrual pelvic pain at some point.

Presentation

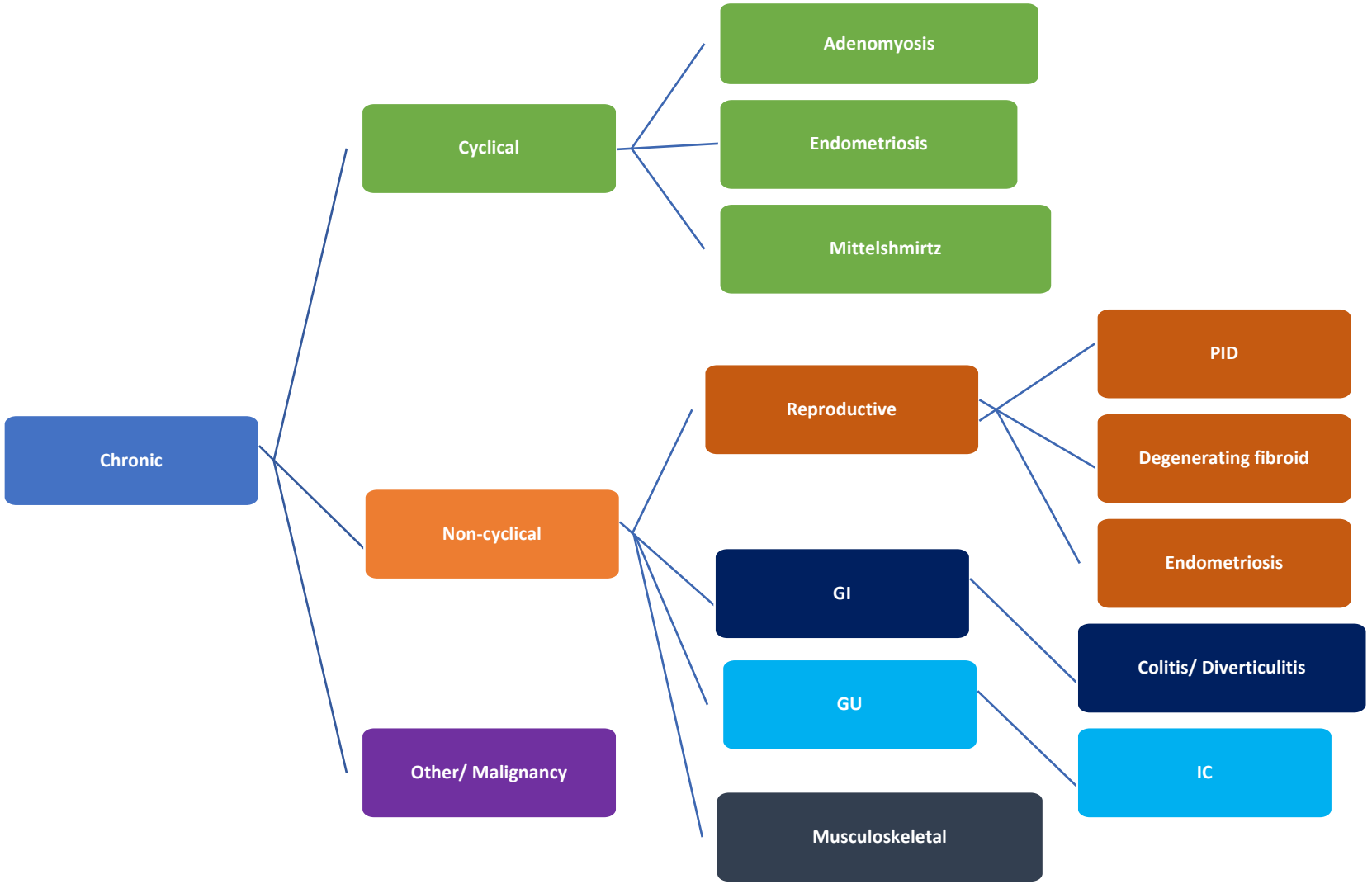
- Sharp shooting
- Dull aching
- Radiation to back or legs
- Periodicity
- Cyclicity
- Associated factors
- Aggravating or relieving factors


Acute pain
Cyclical
Adenomyosis
Endometriosis
Mittelshmirtz
Non-cyclical
Reproductive
Pregnancy related
PID
Torsion
Ruptured cyst
Degenerating fibroid
GI
Colitis/ Diverticulitis
Torsion/ Hernia
GU
Cystitis
Calculus
Musculoskeletal
Other

Where to start? Back to Med school!

History/ History/ History

- Last period:
- Cycles - regularity and association with cycles (mid cycle/ premenstrual/during periods or unrelated)
- Sudden onset/ periodic/ cyclical
- Associated bladder symptoms: Frequency, dysuria, pressure
- Associated bowel symptoms: Constipation (70% of the time fixing this fixes the pain)/ diarrhea/ nausea
- Neurogenic – h/o trauma, disc disease


Chronic
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Non-cyclical
Reproductive
PID
Degenerating fibroid
Endometriosis
GI
Colitis/ Diverticulitis
GU
IC
Musculoskeletal
Other/ Malignancy

PHYSICAL EXAM: Do not skip

Abdominal exam

Tenderness : generalized, localized, rebound

Pelvic (bimanual exam)

Uterine tenderness: PID, adenomyosis

Adnexal tenderness: ruptured cyst, ectopic, PID, diverticulitis, colitis

Suprapubic tenderness: Cystitis, interstitial cystitis

EVALUATION

Pregnancy test:

This is key.

Needs to be performed and

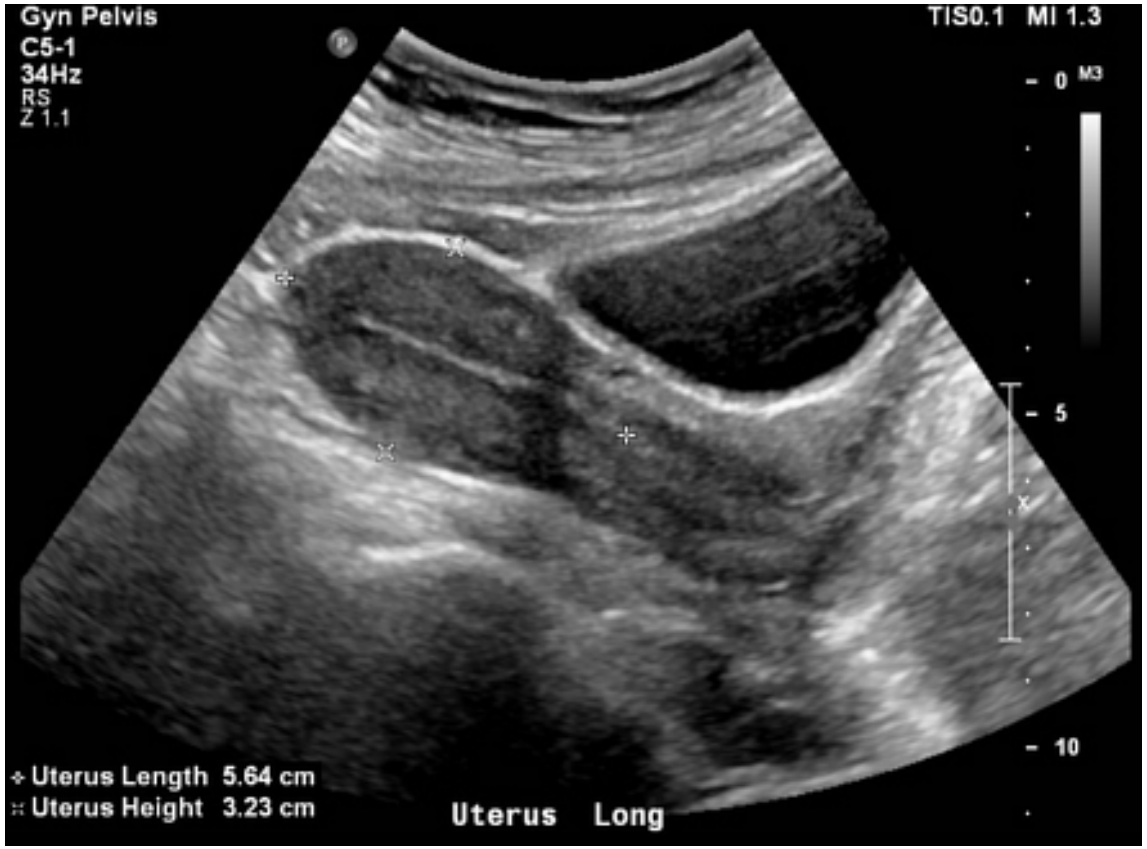
read properly.

Pelvic pain – Evaluation contd.

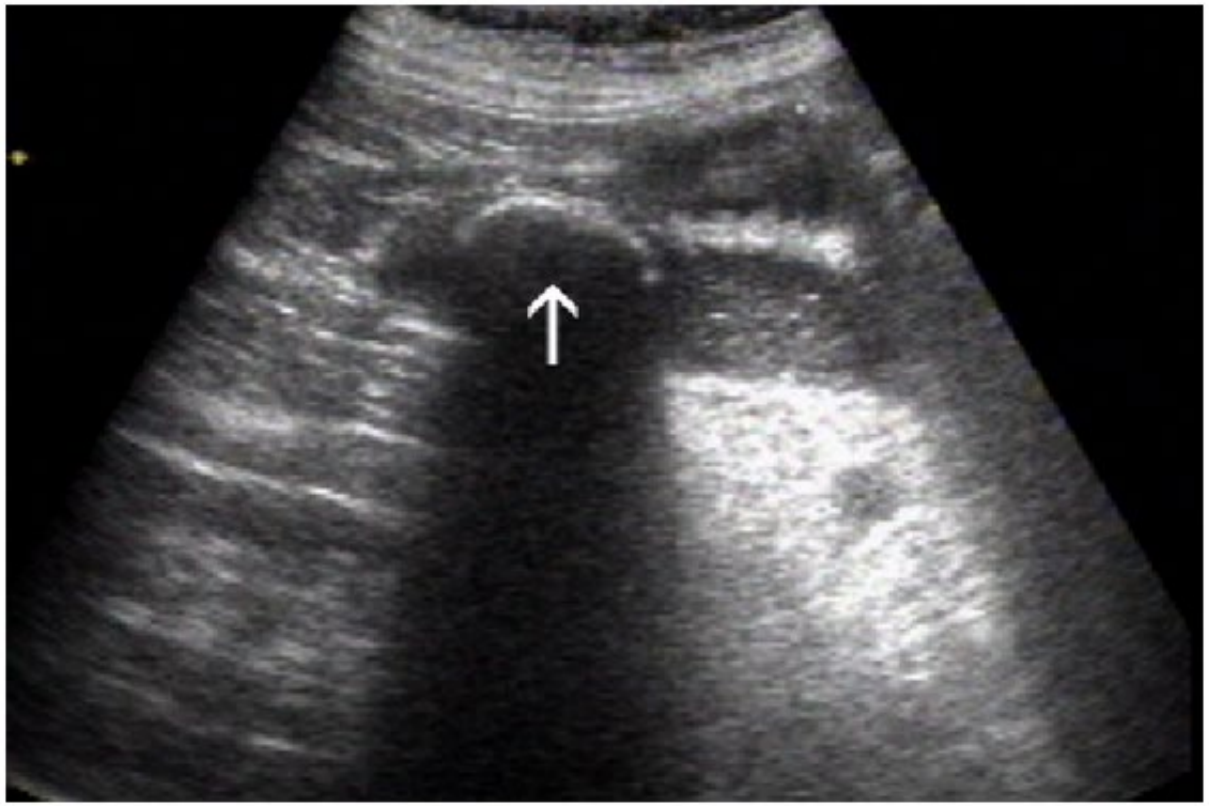
- Ultrasound
- CBC/ HCG/ CMP
- UA, Urine c/s
- STI testing – Urine/ swabs

EVALUATION – Diagnostics - Ultrasound

- **Uterus**- Size/ wall thickness (adenomyosis), fibroids (Fibroids DO NOT cause pain 90% of the time unless degenerating).
- **Adnexa-** hydrosalpinx, hemorrhagic cysts, ruptured cyst, ectopic
- **Cul de sac** - free fluid (ruptured cyst)
- **Bowel** - bowel distention (colitis, diverticulitis, IBS, constipation, food allergies)
- **Ascites**
- **Appendicitis**
- **Liver and GB** – ruptured cyst, gallstones


Gyn Pelvis
C5-1
34Hz
RS
Z 1.1
TIS0.1 MI 1.3
0
M3
5
10
Uterus Length 5.64 cm
Uterus Height 3.23 cm
Uterus Long

Bowel gas

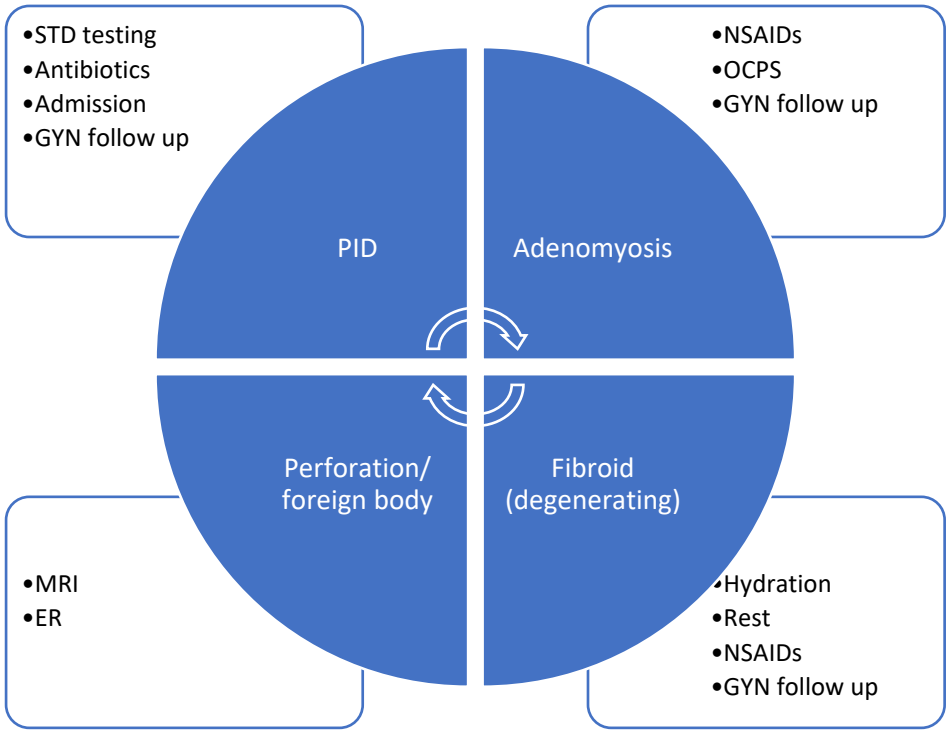


Breaking it down: THINK GLOBAL

Do not blame the poor fibroid or cyst just because it's there.

Always try and get the complete picture even if in an urgent care setting.

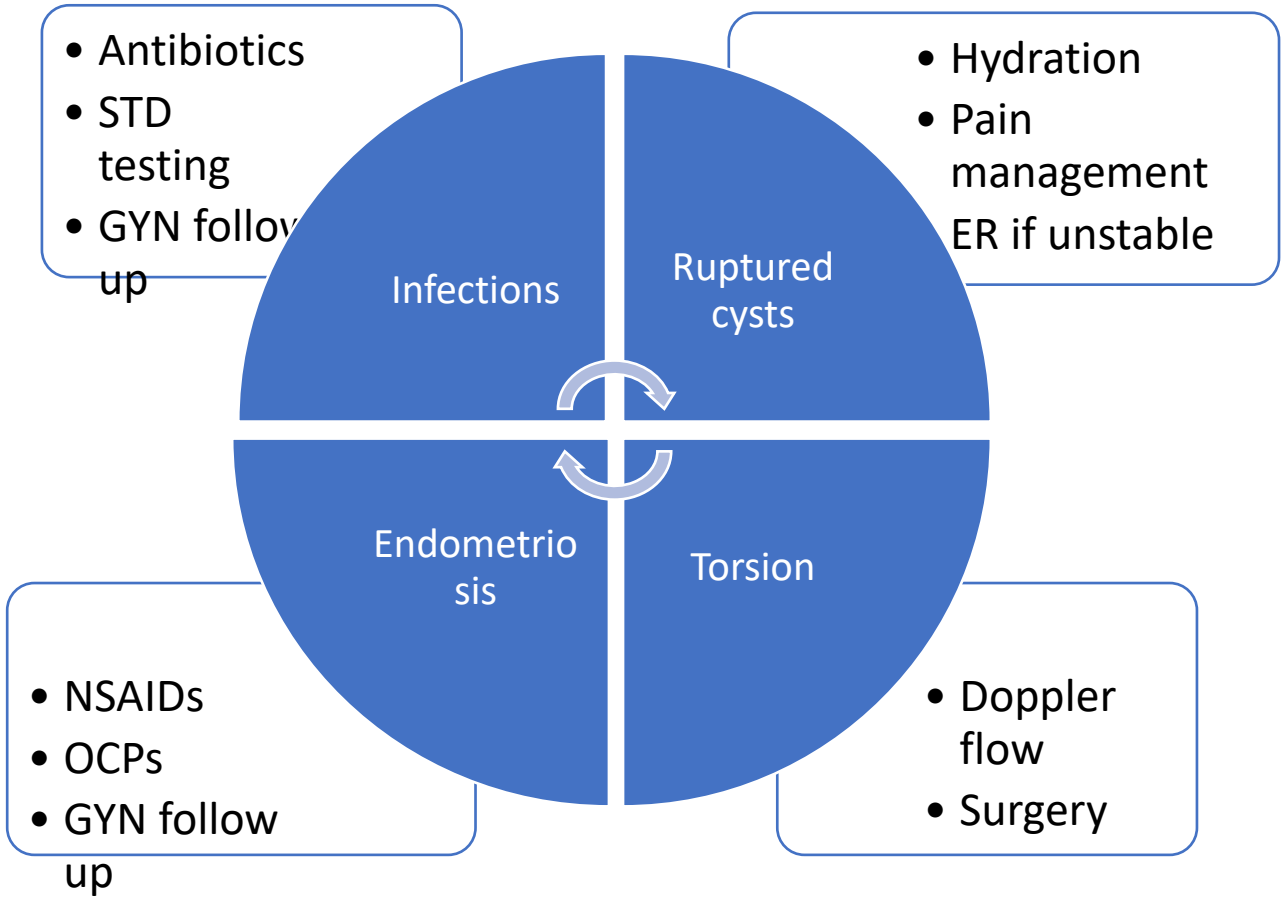
Treatment – Uterine pathology



Pelvic pain Management

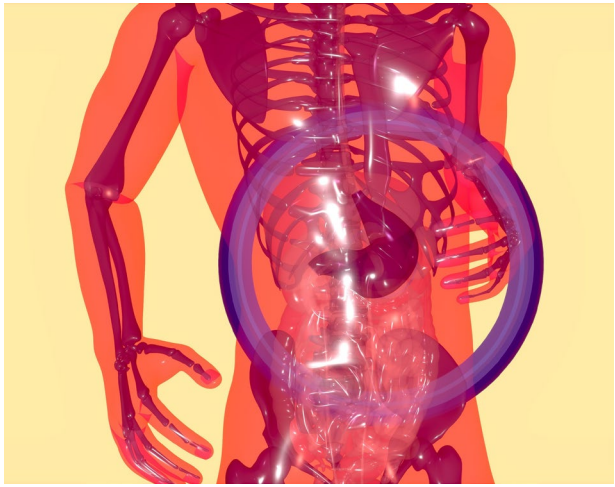
- Reproductive system
  - Early pregnancy – Threatened ab vs ectopic
  - Uterine causes
  - Tuboovarian causes
- Gastrointestinal
- Genitourinary
- Musculoskeletal

Tubo-ovarian pathology

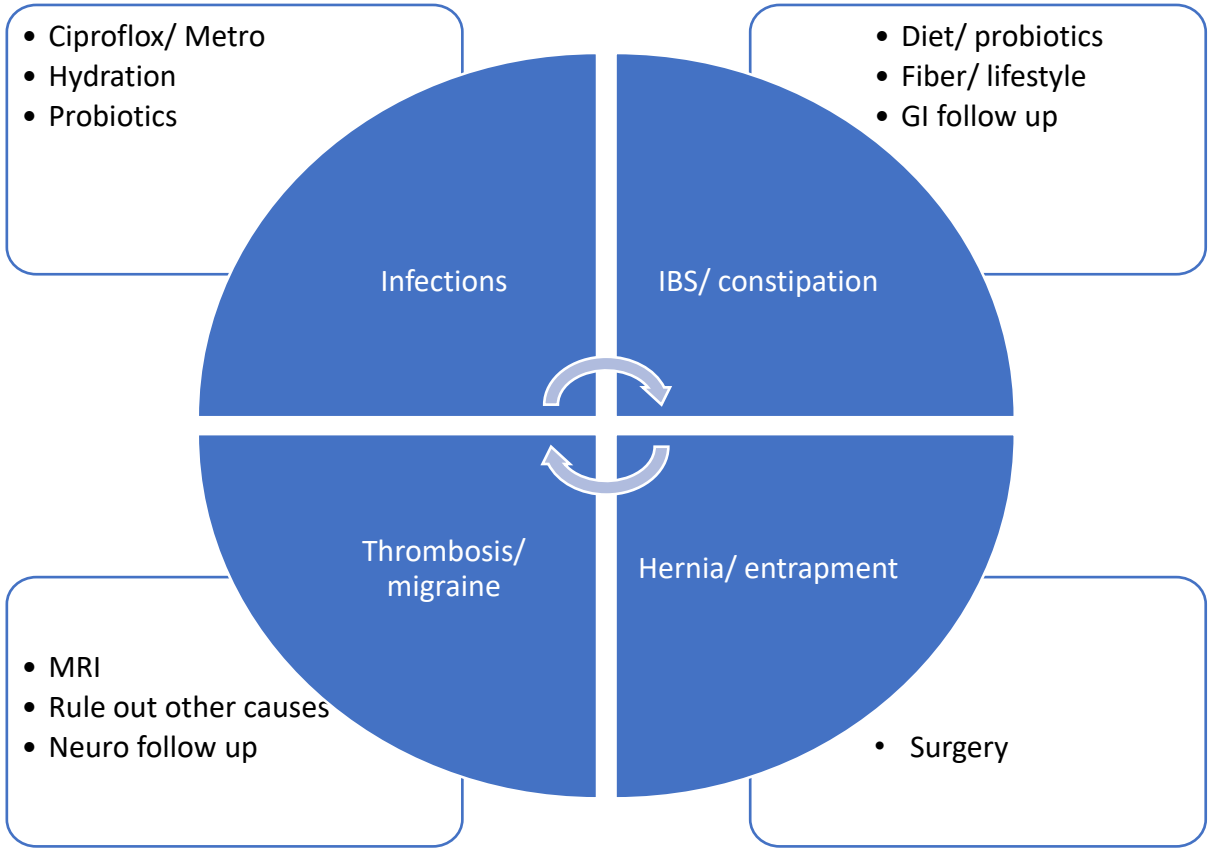


Management – GI causes of pelvic pain

- **Infections** : Colitis/ diverticulitis/ gastroenteritis (pain, fever, diarrhea/ blood in stools, h/o travel, recurrence)
- **Benign-** IBS (recurrent, alternating diarrhea or constipation)
- **Malignant** – colon CA (usually occult and painless)
- Bowel torsion, herniation: h/o surgery, trauma, rare
- Abdominal epilepsy/ migraine/ thrombosis – rare, sudden onset
- Idiopathic
- Malingering/ somatization



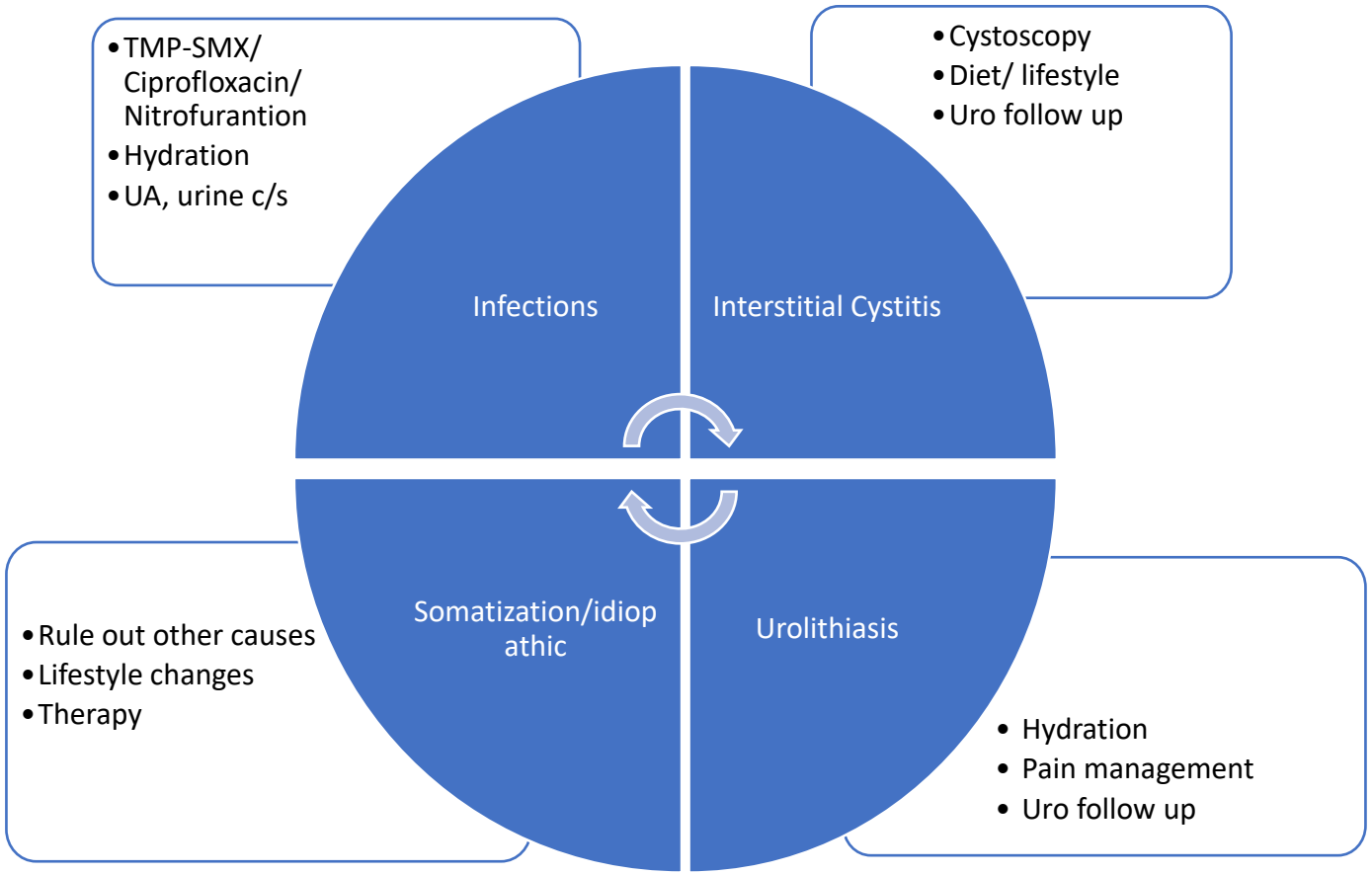
GI pathology treatment



GU system – Causes and management

- **Infection:** Cystitis, UTI (frequency, dysuria, fever)
- **Benign:** Interstitial cystitis (chronic suprapubic pain, frequency, dyspareunia)
- **Urolithiasis** (sudden onset sharp pain, radiating to flank)
- Malignant- painless hematuria
- Somatization – Anxiety
- Idiopathic

GU pathology - treatment



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2. Early Pregnancy

<u>Common presenting complaints:</u>

- Missed period

- Irregular periods

- UCG +

- Pelvic pain

- Nausea/ vomiting

Early Pregnancy- initial work up

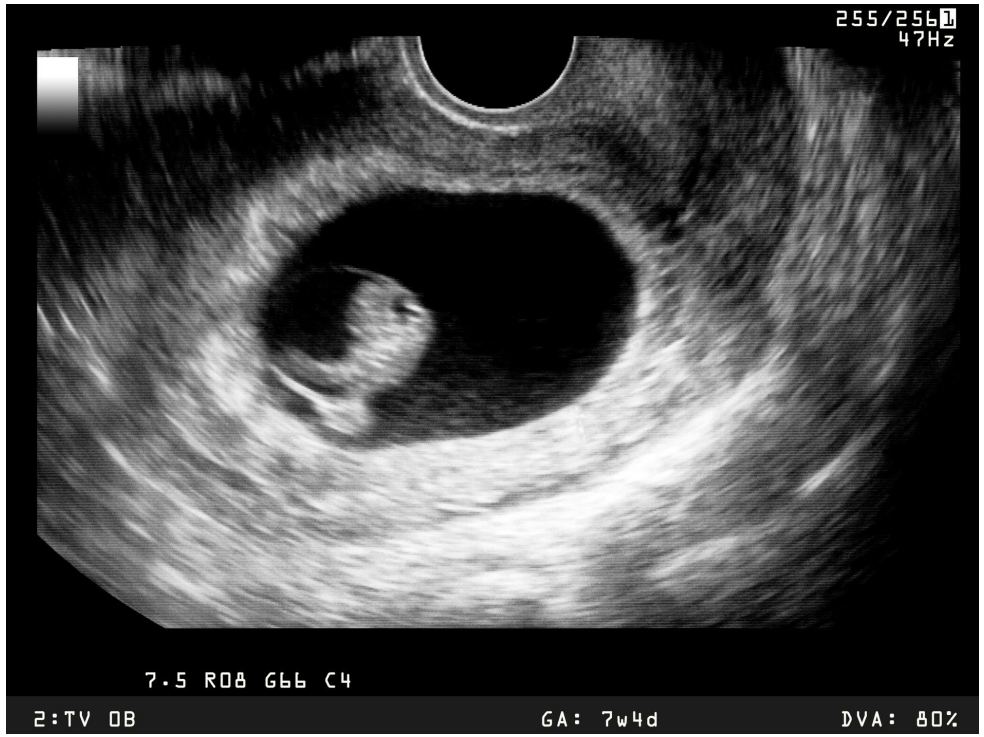
BLOOD WORK

- CBC
- HCG
- CMP
- ABO-Rh
- GCT screening/ pap

SONOGRAM

Transabdominal/ Transvaginal

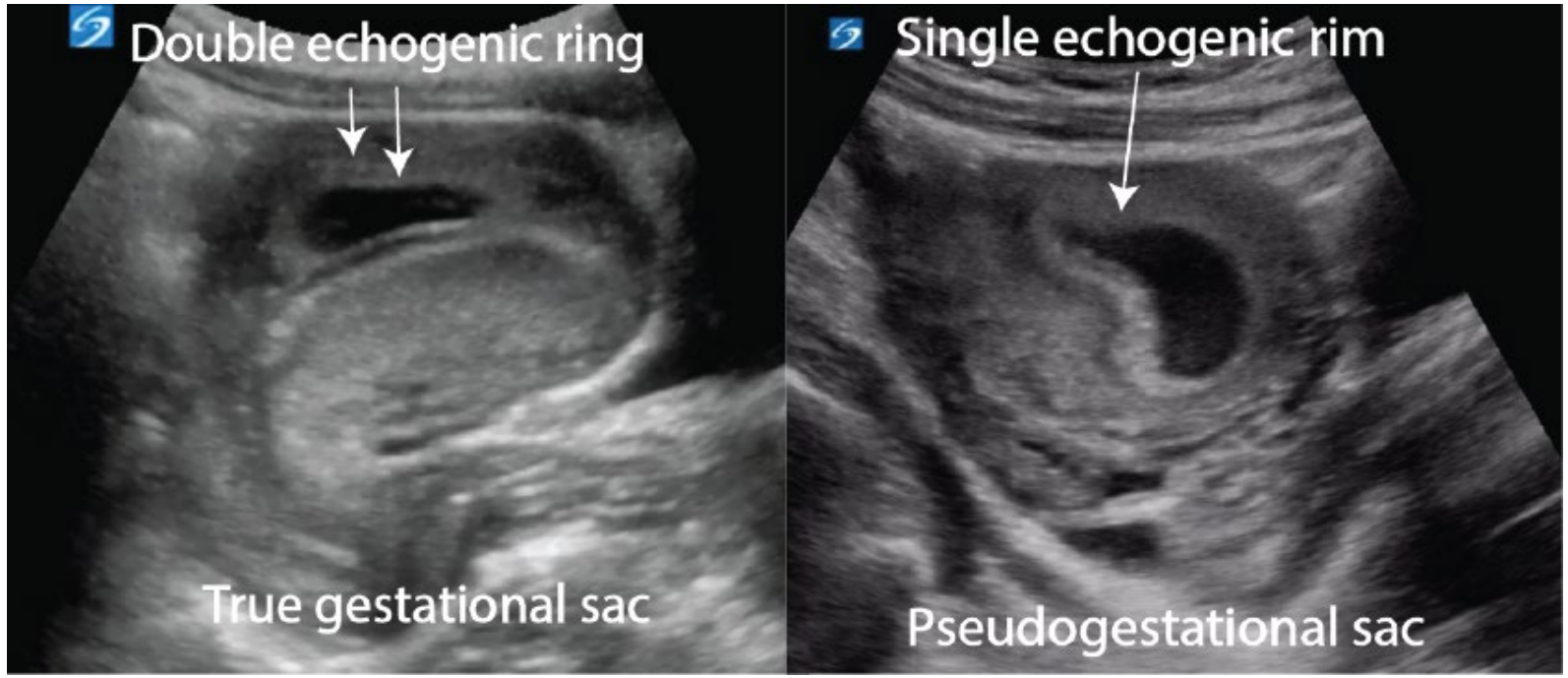
Ultrasound- G sac & yolk sac



If IUP (G sac/ yolk sac/ Fetal pole) present: Threatened ab

- Rest
- Hydration
- Follow up with OBGYN in 24-48 hrs
- Rhogam if bleeding and Rh neg

Ultrasound – pseudo sac



Early Pregnancy – no IUP (PUL)

•High index of suspicion

<u>Differentials</u>

- Ectopic pregnancy

- Missed abortion

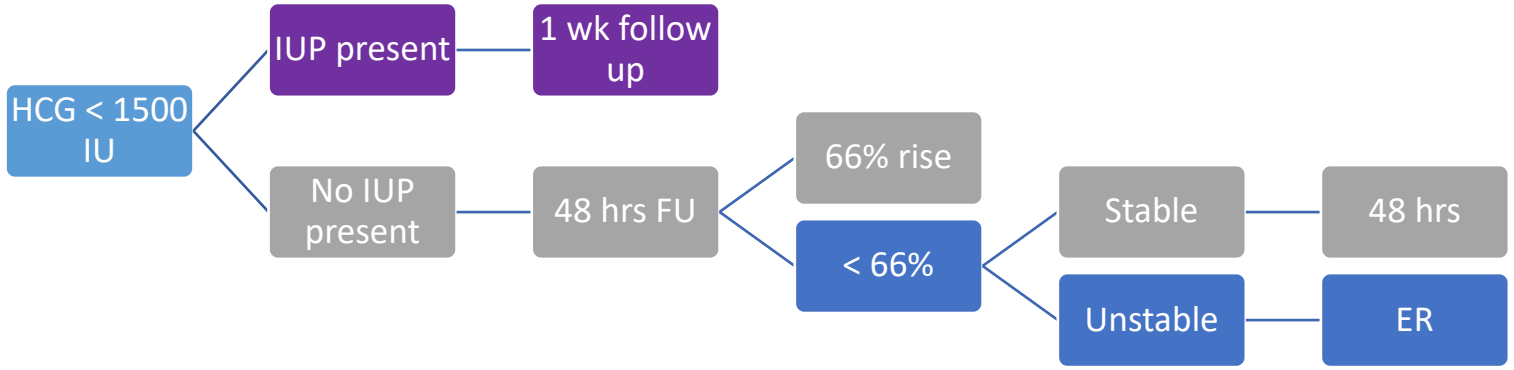
- Early pregnancy

- Incomplete abortion

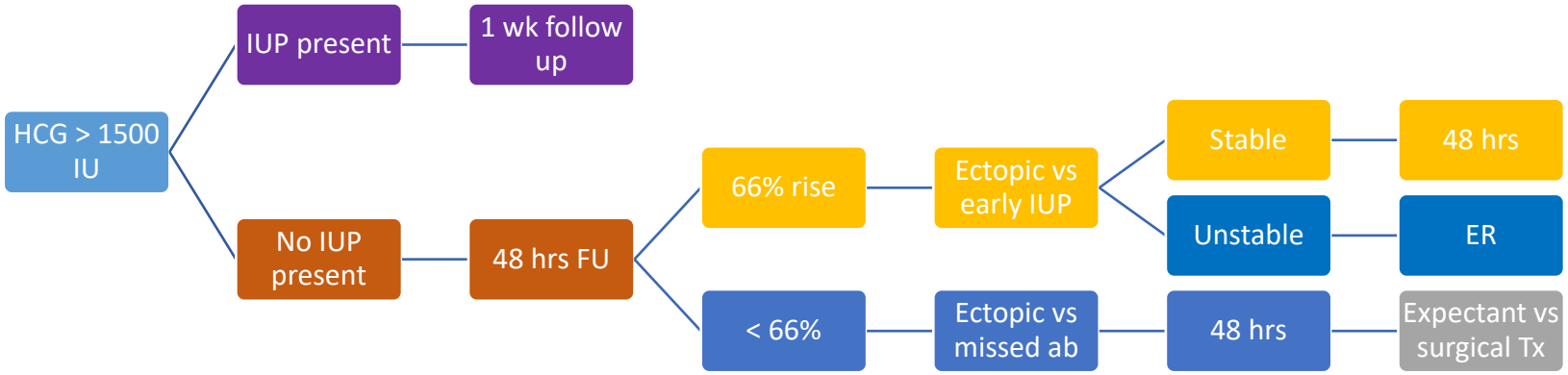
HCG- Diagnostic value

- In early pregnancy, serum hCG levels increase in a curvilinear fashion until a plateau at 100,000 mIU/mL by 10 weeks of gestation.
- A single hCG concentration measurement cannot diagnose viability or location of a gestation.
- If no IUP (G sac/ yolk sac) identified, a second hCG value measurement is recommended 2 days after the initial measurement to assess for an increase or decrease.
- Subsequent hCG concentration should be obtained 2–7 days apart, depending on the pattern and the level of change.

Early Pregnancy work up: HCG < 1500



Early Pregnancy work up: HCG > 1500 IU



Early Pregnancy work up

- High index of suspicion
- If Rh negative pt with bleeding/ pain > Rhogam 300mcg (unless partner is confirmed Rh neg)
- 48 hr HCG and 1 wk sono follow up safer if not sure
- Sono – IUP is reassuring
- Correct interpretation of sono findings is important (look of the G sac/ thickened ET)
- Free fluid on sono – suspected ruptured ectopic
- Do not get misled by the last period (plan B/ IUDs/ PCOS etc)

Prenatal counseling

- PNV with DHA (OTC ok)
- Vitamin D – 5000 IU total
- Probiotics
- Normal exercise ok (avoid high impact or new regimens)
- Avoid uncooked raw foods/ unpasteurized cheeses.
- Hydration
- Small frequent meals

[insert pic]

3. Vaginal infections

- 6-10 million health care visits per year
- Itching, irritation, burning, discharge.
- Most common reason for a GYN visit
- 10-20% can turn into recurrent issues
- Look for underlying immune issues, diabetes and lifestyle issues

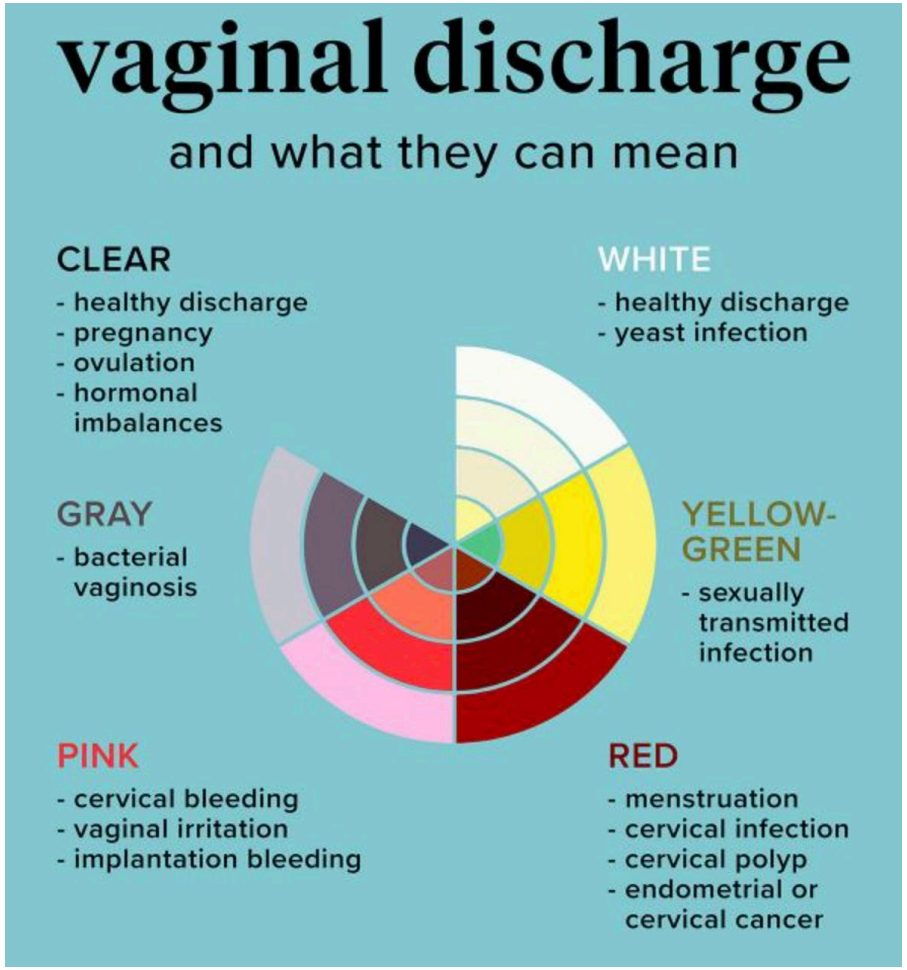
The most common causes of vaginitis are:

- Bacterial vaginosis (22–50% of symptomatic women)
- Vulvovaginal candidiasis (17–39%), and
- Trichomoniasis (4–35%);
- 7–72% may have mixed or non-specific vaginitis

Common vaginal issues and causes

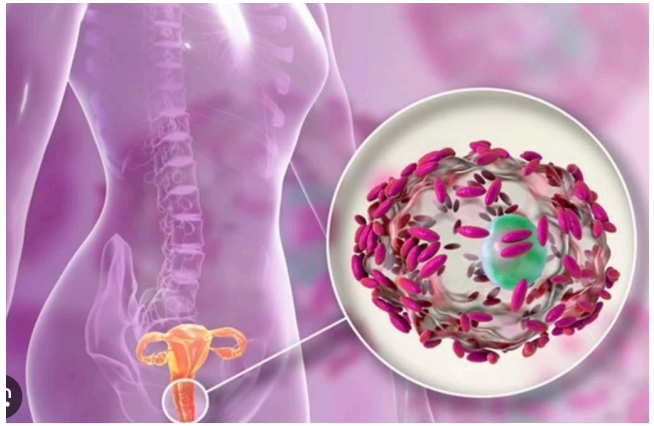
- Itching
- Burning
- Pain
- Discharge
- Dryness
- Generalized discomfort
- Sexual issues

Vaginal Discharge



Bacterial Vaginosis- Diagnosis (add pics)

- **Clinical –** Vaginal discharge – gray/ green/ yellow. Fishy smell. Increases before or after periods.
- **Swab –** positive for *Gardnerella*/*Ureaplasma* etc.
- **pH –** alkaline
- Cultures – Usually needed if recurrent BV. Add *Ureaplasma* and Myco if recurrent.



Bacterial Vaginosis- Rx

- **Oral METRONIDAZOLE** – 500mg twice daily x 7 days. (95% effective).
- Vaginal – **Metronidazole 0.75% gel (Metrogel®) intra-vaginal application** – bedtime x 5 days (85% effective).
- Tinidazole 500mg PO BID x 5 days

First episode or alternative Rx (insurance permitting)

- – Can try Secnidazole (Solosec®)- 2g powder x 1
- - Metronidazole 1.3% gel (Nuvessa®) vaginal one dose

Alcohol is no longer a contraindication

BV Treatment considerations

- Clindamycin ovules use an oleaginous base that might weaken latex or rubber products (e.g., condoms and diaphragms). Use of such products within 72 hours after treatment with clindamycin ovules is not recommended.
- Women should be advised to refrain from sexual activity or to use condoms consistently and correctly during the BV treatment regimen.
- Douching might increase the risk for relapse, and no data support use of douching for treatment or symptom relief.

BV- Alternate treatments

- **Secnidazole:** BV clinical cure rates at days 21–30 were 53% in the secnidazole arm compared with 19% in the placebo arm

- **Metronidazole** 1.3% vaginal gel (Nuvessa®) and **Clindamycin** phosphate (Clindesse®) 2% vaginal cream in a single dose: BV clinical cure rates at day 21 were 37.2% in the metronidazole 1.3% vaginal gel arm, compared with 26.6% in the placebo arm.

Vulvovaginal Candidiasis

- An estimated 75% of women will have at least one episode of VVC, and 40%–45% will have two or more episodes.
- 5%–8% subsequently develop recurrent VVC (RVVC), defined as 4 or more episodes per year in the absence of predisposing factors.
- In addition to causing symptomatic disease, *Candida spp*. can also colonize the vagina in approximately 15%–20% of asymptomatic women.
- *Candida albicans* is the most common *Candida spp*. associated with VVC although *C. glabrata, C. tropicalis*, and rarely other *Candida spp*. are also implicated.

Vulvovaginal candidiasis- VVC

Clinical Diagnosis

- Cottage cheese/ yoghurt-like dis
- Itching inside and outside the va
- Redness in the vulvar region
- Recent antibiotics
- Diabetes/ Obesity.

VVC- Diagnosis

Diagnostic tests

- Visual inspection.
- pH - Acidic
- PCR (NAAT)– swab – One swab/ pap spatula/ Uno
- KOH Microscopy – Fungal hyphae – test not available easily.
- Advanced testing – NGS (see later slides)

VVC - Treatment

- FLUCONAZOLE: 150MG PO X1 (Most effective – 97% clearance rate)
- If recurrent or severe – Repeat in 3 days x 3 doses.

<u>If vulvo-vaginal symptoms</u>

- LOTRISONE® LOTION (Clotrimazole + Betamethasone) 1 % Local application BID x 7days. Do not give if HSV ulceration present.
- Terconazole (Terazol 3®) – 0.8% vaginal applicator x 3 days OR
- Terconazole (Terazol 7®) – 0.4% vaginal applicator x 7 days

Recurrent Candida

- Fluconazole 150mg weekly for 3-6 months + *recurrent BV Rx*
- Or
- Clotrimazole 2% vaginal twice weekly x 3-6 months.

Fluconazole allergy or resistance

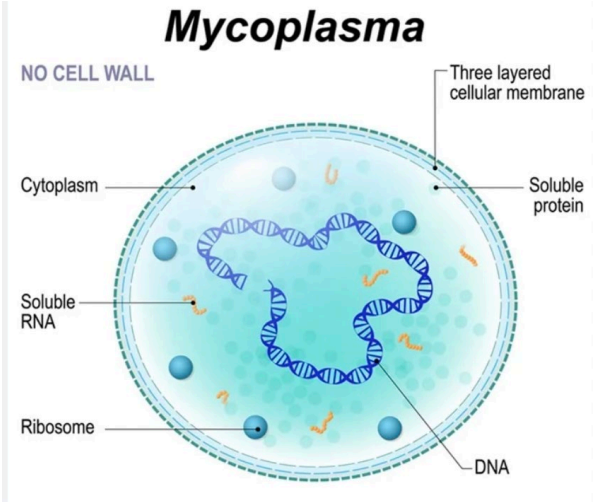
- Nystatin suppositories – 100,000 IU vaginal daily x 14 days.
- Boric acid suppositories – 600 mg vaginally daily x 30 days (Needs to be compounded – paper Rx – not covered by insurance)
- Gentian Violet daily application x 14 days
- Ibrexafungerp (Brexafemme®)
- Oteseconazole (Vijoa®)

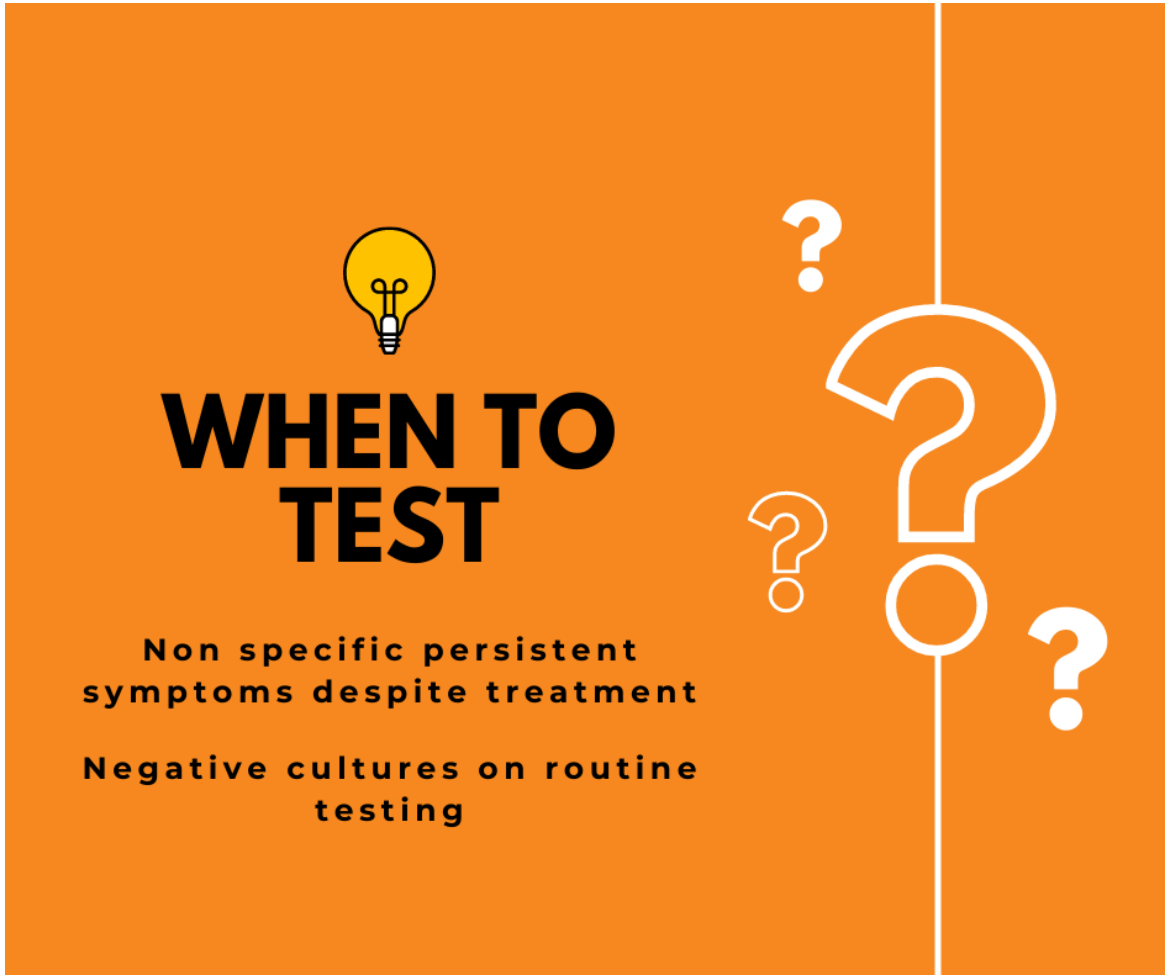
Trichomonas/ Chlamydia/ Gonorrhea

- See protocols/ CDC
- Can present with non specific symptoms such as pain/ discomfort/ minimal discharge/ dysuria etc
- Mostly asymptomatic
- Partner treatment essential
- Partner reporting website:

Mycoplasma & Ureaplasma

- *Mycoplasma* and *Ureaplasma* are the smallest free-living organisms. They lack a cell wall, therefore neither *Mycoplasma* nor *Ureaplasma* can be visualized by routine gram stain microscopy.





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WHEN TO TREAT

No response to routine Rx

Recurring infections after sexual intercourse

Persistent burning and discharge with negative cultures

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Treatment - *M. genitalum*

If resistance testing not available

- **Doxycycline** 100 mg orally 2 times/day for 7 days, followed by **moxifloxacin** 400 mg orally once daily for 7 days.

If resistance resting available (not available at present for commercial use).

- **If *macrolide-sensitive:* Doxycycline** 100 mg orally 2 times/day for 7 days, followed by **azithromycin** 1 g orally initial dose, followed by 500 mg orally once daily for 3 additional days (2.5 g total)
- **If macrolide-resistant: Doxycycline** 100 mg orally 2 times/day for 7 days followed by **moxifloxacin** 400 mg orally once daily for 7 days

Ureaplasma

- **Doxycycline:** 100mg PO BID X 10 days (14d if PID)

In cases of treatment failure or resistance, fluoroquinolones are another option.

❑ **Levofloxacin** 500mg BID x 10 d (14d if PID)

Or

❑**Moxifloxacin** 400mg once daily x 10 d

- *Clindamycin not effective against *Ureaplasma*
- Macrolides (azithro/ erythron) have high resistance.

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URGENT CARE
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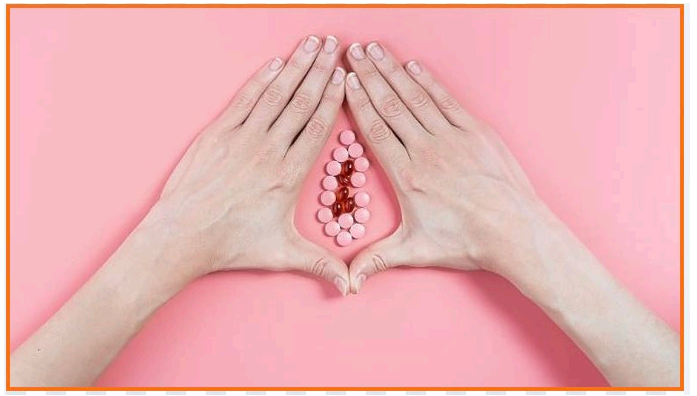
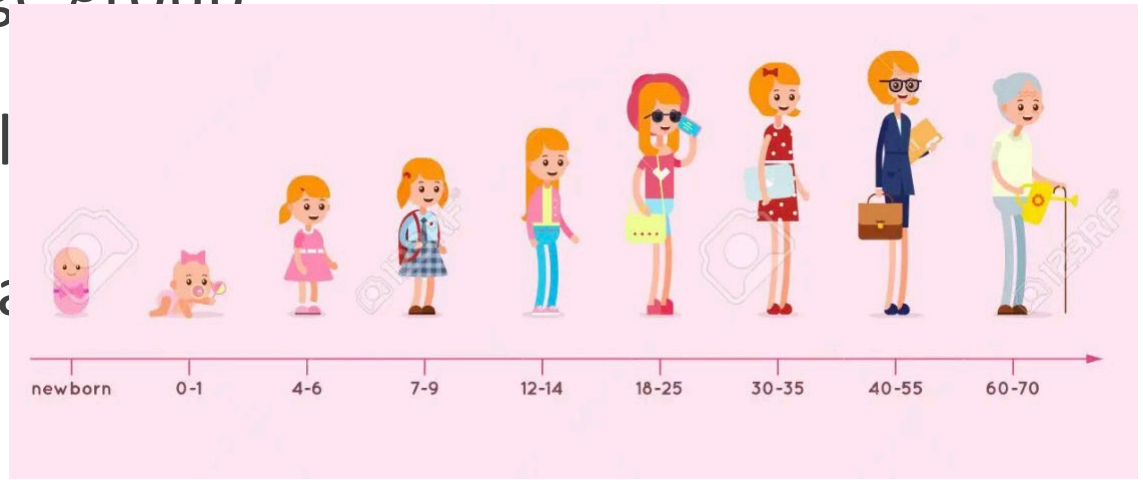
4. Abnormal vaginal bleeding

- Over 50% women will have abnormal vaginal bleeding in their lifetime
- Age
- Rule out pregnancy



Age

- Puberty
- Reproductive age group
- Perimenopausal
- Post-menopausal

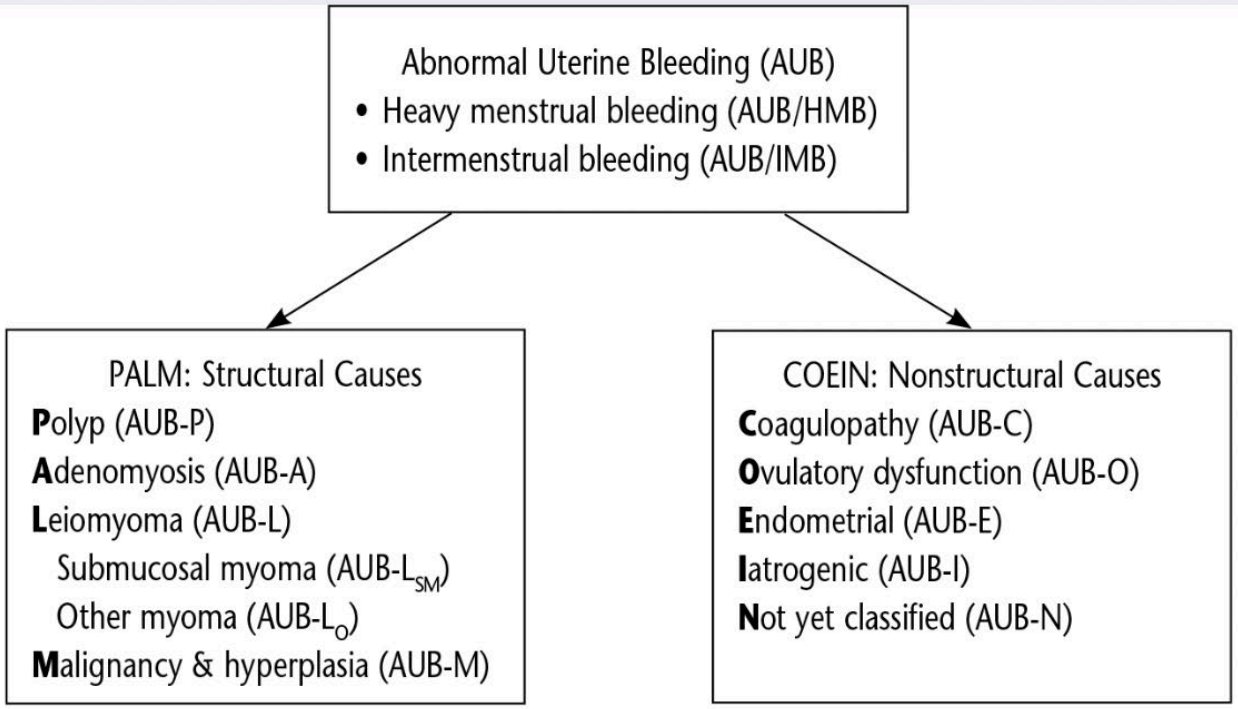


Causes- PALM-COEIN

- **P**olyps
- **A**denomyosis
- **L**eiomyoma
- **M**alignancy

- **C**oagulopathy
- **O**vulatory dysfunction
- **E**ndometrial
- **I**atrogenic
- **N**ot otherwise classified

PALM- COEIN



Initial approach : History

- Menstrual history : Flow/ frequency
- When did it change?
- Precipitating factors (Covid/ steroid injections/ stress/ weight changes)
- Hematuria
- Post-coital bleeding
- h/o trauma or genital manipulation
- Hemodynamic status (dizziness etc)
- Other associated symptoms – pain, constipation, dysuria

Initial approach

Pregnancy test:

This is key.

Needs to be performed and

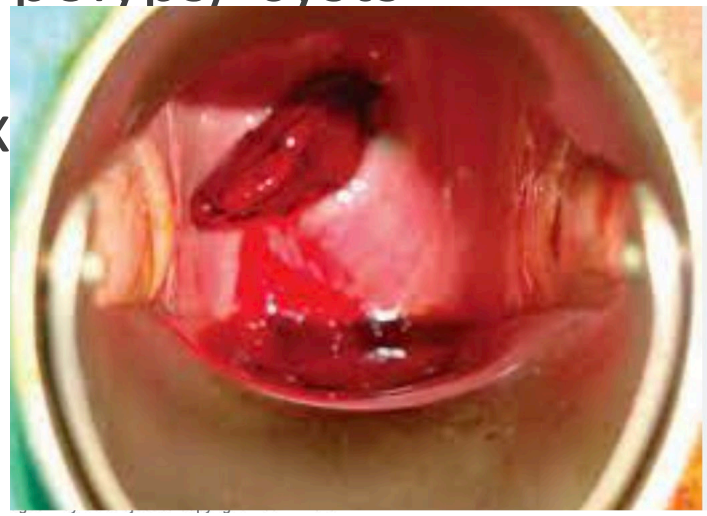
read properly.

Physical exam (if sexually active)

Inspection

-External visualization – trauma/ polyps/ cysts

-Speculum exam – Source (cervix



Pelvic exam

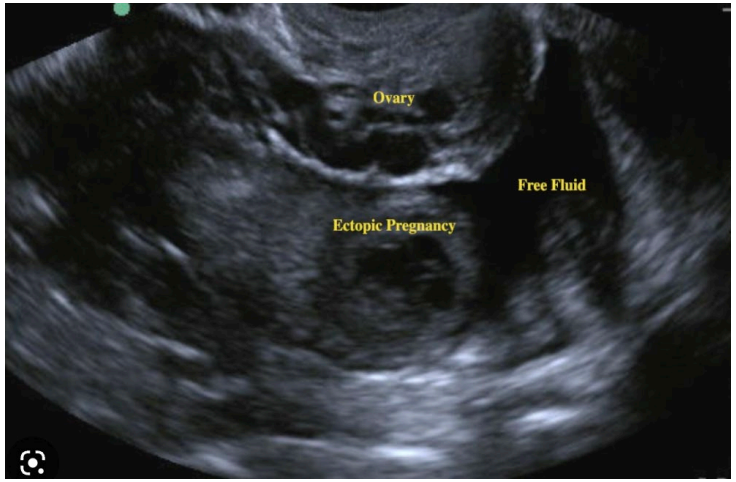
-Bimanual (fibroids/ adnexal mass/ cysts)

Labs

- CBC
- TSH
- Prolactin
- HCG quantitative

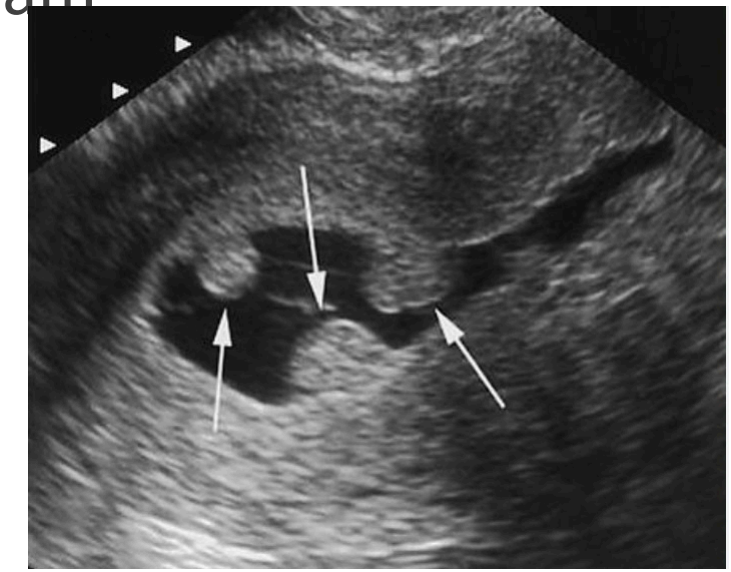
If positive pregnancy test, always rule out ectopic

- Pelvic sonogram
- HCG quantitative
- Follow up with OBGYN in 48 hrs
- ER if severe pain/ bleeding/ dizziness/ syncope



Imaging

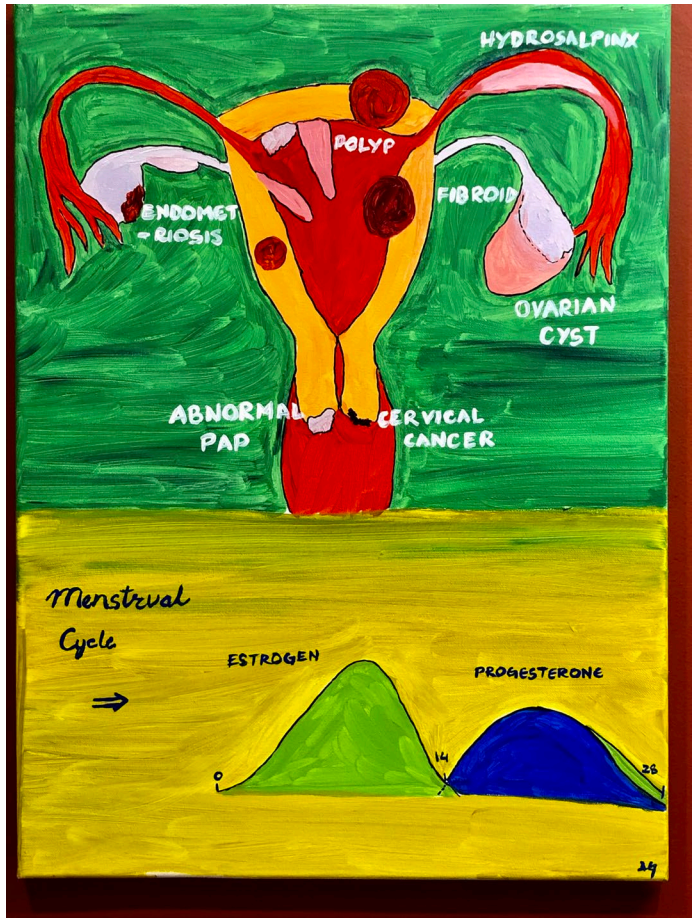
- Pelvic transvaginal sonogram



Management depends on:

- Age
- Pathology
- Precipitating factors

Pathology



Puberty

- Puberty Menorrhagia most common
- VwF and Pt/PTT testing
- Combination contraceptives (sta

  cycle) – OCPs/ Nuvaring®
- Offer STI testing
- Refer to GYN for follow up in 2 wks

Reproductive age group

- Correlate with prior menstrual history
- Depends on the cause
- Pelvic sonogram is key
- OCPs (progesterone only)/ Mirena®/ Ablation/ UFE/ Gn RH analogues/ hysterectomy
- Do not start hormones without ruling out pregnancy
- Plan B is a common cause and can cause misdiagnosis

ALWAYS CONSIDER ENDOMETRIAL BIOPSY IF:

- risk of metabolic syndrome

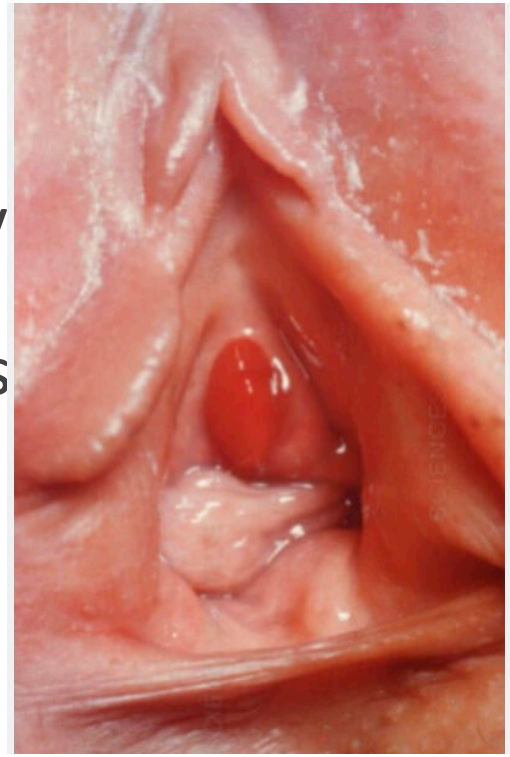
- family history s/o high risk of endometrial cancer

- PCOS

- HTN/ BMI > 30

Post menopausal

- Pelvic sono
- If ET > 4mm - Endometrial biopsy
- If ET < 4mm – likely atrophic caus
- Urethral caruncle (Estrogen Rx)
- Rectal bleeding – GI referral



Few notes on management of acute AUB

Sono is a must.

If no risk factors, HCG neg, Bx neg (if indicated)

ET thick (>10mm)

- Medroxyprogesterone (Provera®) 10mg PO daily x 21 days > 1 wk break > consider OCPs

ET thin (<10mm)

- OCP taper

Apri® – 1 tab 3x daily x 2 days > twice daily x 2 days > 1 daily till end of the pack

Notes on management of AUB contd.

- If unsure of diagnosis or;
- No biopsy available:

Tranexemic acid 500mg 3 times a day with food x 5 days

- reduces blood flow x 50-55%

Questions (insert awards pic)

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