

The Modern Well Woman: Frequency of the Well Woman Visit and Necessity of Pelvic Examination in the Digital Era

Takeko Takehsige*, Umeko Takeshige and Sheyna Gifford

Department of Clinical Obstetrics and Gynecology, Weill Cornell Medical College, USA

***Corresponding Author:** Takeko Takeshige, Assistant Professor, Department of Clinical Obstetrics and Gynecology, Weill Cornell Medical College, 1300 York Ave, New York, NY 10065, USA.

Received: July 26, 2016; **Published:** August 11, 2016

Modern medical technologies are constantly advancing. Medical researches utilizing digital informatics leading to cutting-edge diagnostic and therapeutic interventions and resulting in updates on clinical guidelines for evidence-based medicine [1,2]. Such is currently the case with questioning the necessity of the pelvic examination and frequency of the Well Women visit. Due to insufficient data to support its ongoing use in the digital era; the basic procedure itself, as well as the need for an annual assessment by a gynecologist continue to generate substantial debate in the United States. In moving forward with this discussion, it is critical for us to remember the fundamental elements of the Well Woman examine and principles that have guide us to care for patients using these practices still apply- in some ways, now, more than ever.

Well Women visits serve a dual purpose: to promote and maintain healthy lifestyles, and to minimize potential health risks in order to sustain higher life expectancy with good quality of life. In order to achieve these goals, during Well Women visits, patients are divided into four groups by physiologic age: (1) 13-18 years-old or adolescent; (2) 19-39 years-old or reproductive; (3) 40-64 years-old or perimenopausal to menopausal; and (4) age 64 and above or postmenopausal [3]. These divisions are important, as each age group has indicators and risks factors specifically screened for during each Well Women visit.

Screening

In the era of digital health, electronic medical records under the Affordable Care Act (ACA) have enabled physicians to build customized templates to facilitate Well Women visits that include all of the appropriate ICD-10 codes. These templates should be tailored individually to enhance acquisition of a detailed obstetrical and gynecological history. During the interview and screening portion of these visits, any chief complaint should be noted. An annual assessment should also be completed, including a review of the patient's gynecologic history and a complete past medical and surgical history. This assessment should include extensive documentation of allergies to medications, foods and other substances such as latex; a medication reconciliation, including current use of complementary and alternative medicine; a complete social history with tobacco, alcohol and other drug use; and a family medical history. Once reviewed, this information is then added into the patient's medical record and made available for future use by the patient and her providers.

Ideally, attention should be paid to each patient's lifestyle, including living situation and physical activities; dietary and nutritional status, and emotional and psychiatric issues, and sexual practices. Each of these plays an important role in the patient's current and future health, as does the next item on the list: screening for cancer. Emergent changes in cancer mortality data from American Cancer Society (ACS) have demonstrated that, in women, cancer of the lung is the most lethal, followed by breast, colorectal, ovarian and uterine cancer. Assessments made during the Well Woman visit should therefore include age-appropriate screening for risk factors for these cancers. Risk factors for breast cancer are of particular concern. The ACS estimated that in 2016 there will be more than 246,000 new cases of breast cancer, making it the most common female cancer in the US [4]. Assessment for common etiologies of female mortality from stroke, ischemic heart disease, and diabetes is warranted and extremely valuable in age-appropriate groups.

Citation: Takeko Takeshige., *et al.* "The Modern Well Woman: Frequency of the Well Woman Visit and Necessity of Pelvic Examination in the Digital Era". *EC Gynaecology* 3.4 (2016): 310-313.

The life-saving and healthcare-cost-saving potential of this portion of the Well-Women exam is difficult to over-estimate: increased doctor-patient communication results in greater patient satisfaction as well as some proven improved health outcomes [2,5].

Physical Evaluation and Counseling

The physical portion of an annual examination includes vital signs; a BMI (body mass index) measurement; and a lymph node, breast, abdominal, and pelvic examination. The rectovaginal examination may be done on indicated patients. Pelvic examination consists of three parts: (1) external inspection of external genitalia, urethra meatus, vaginal introits, and perianal region; (2) internal speculum examination of vagina and cervix and; (3) the bimanual examination of cervix, uterus, and adnexal [6].

As previously mentioned, the necessity of performing a pelvic examination during a Well Women visit has generated debate, and rightfully so. Pelvic examinations require women to remove clothing from waist downwards, to wear disposable paper gowns, and to be placed in a dorsal lithotomic position while awaiting examination. This position is uncomfortable for women, and the question of whether the potential benefits of this portion of the exam outweigh the discomforts is appropriate. Here is our point-of-view, based on years of experience and a knowledge of the literature: for symptomatic women with abnormal uterine bleeding, vaginal discharge, pruritus and discomfort, pelvic pain, infertility, or change of bowel and/or bladder functions, pelvic examination is warranted. However, for low-risk and asymptomatic women, insufficient data exists to either support or refute the practice of annual pelvic examination.

Here is the most recent evidence: in 2014, "Screening Pelvic Examination in Adult Women," was published in the *Annals of Internal Medicine*. The included studies evaluated the ability of pelvic examination to accurately identify infections like BV and PID, and gynecological malignancies excluding cervical cancer from 1946 through January 2014. The pooled results indicated that pelvic examination had low diagnostic accuracy for both bacterial vaginosis and ovarian cancer [7]. It made no other claims regarding the ability of pelvic examination to diagnose other gynecological pathologies, such as PID and cervical cancer.

As a direct result of this meta-analysis, on July 1, 2014, the American College of Physicians (ACP) issued a new guideline: recommending against the use of screening pelvic examinations in asymptomatic, non-pregnant, adult women. On June 25, 2016, the United States Preventive Services Task Force (USPSTF) released a draft statement regarding the use of pelvic examination in asymptomatic, non-pregnant adult women. The statement reported that there was insufficient evidence regarding the benefits and risks associated with the pelvic examination to make a recommendation either for or against it, and opened their website to public comment [8]. In response to the USPSTF's statement, major American newspapers wrote articles entitled, "Pelvic Exams May Not Be Needed" (*The New York Times*, June 28, 2016) and "The Days of the Dreaded Annual Pelvic Exam for Women May Be Numbered" (*The Washington Post*, June 28, 2016) [9,10]. On June 28, 2016, the American College of Obstetrics and Gynecology (ACOG) released its own statement: reaffirming its recommendation for annual pelvic examinations in women above the age of 21.

After the Physical Exam: Laboratory Tests, Counseling, and Immunizations

Armed with the above information, health care providers can assist patients in understanding the current conflicting recommendations and decide for necessity of the pelvic examination. The remainder of the visit must include standard of age and risks appropriate laboratory tests; age-appropriate counseling; and recommended immunizations based on age group and risk factors.

The laboratory testing guidelines are as follows based on age and risks factors (for patients who have no recent results documented elsewhere):

- Cervical cytology testing
- Sexually transmitted infections testing such as Chlamydia and Gonorrhea, hepatitis C virus
- Human Immunodeficiency Virus (HIV)

- Diabetes testing, cardiovascular, renal and liver testing
- Thyroid-stimulating hormone testing
- Mammography, colon cancer testing
- Osteoporosis testing

The counseling guidelines based on age groups are as follows [11-13]:

- 1) For the adolescent group: contraception and sexually transmitted infections, patient self-image, and nutritional status.
- 2) For the reproductive group: conception with folic acid supplementation, family planning options, life style modification with exercise and weight issues, smoking cessation, cervical and breast cancer screening.
- 3) For the peri-menopausal-to-postmenopausal group: vasomotor symptoms, pelvic organ prolapsed, incontinence, lung, colorectal, cervical and breast cancer screening, osteoporosis screening and life style modification, and discontinuation of certain screening tests.

In accordance with national guidelines, the following are recommended vaccinations to discuss during Well Women visits (in the age-appropriate groups) if they have not been received or documented elsewhere [2]:

- Diphtheria and reduced tetanus toxoids and acellular pertussis vaccine booster
- Hepatitis B vaccine
- Human papillomavirus vaccine
- Annual influenza vaccine
- Measles-mumps-rubella vaccine
- Meningococcal conjugate vaccine
- Varicella vaccine Zoster Vax or Pneumovax

Conclusion

In the US, women used to see gynecologists annually for cervical cancer screening and pelvic examination. In the new era of the digital health, clinical guidelines were updated for both frequency of the cervical cancer screening and the pelvic examination. Cervical cancer screening intervals have been revised to every 3 years for women of age between 21 and 29; and every 5 years for women above age of 30. As a result of these changes and recent study results, pelvic examination intervals are encountering challenges by the medical experts and patients. While we await sufficient evidence regarding the benefits of annual pelvic exams, it is important to remember that there are many established indicators for patients to continue receiving annual Well Women visits with gynecologists. Benefits of these visits include extensive screening, basic physical exams and laboratory tests, counseling, and preventative medicine services. Far from being expendable for lack of extensive supporting evidence regarding one small aspect of the encounter, Well Women visits meet and generally exceed their basic goals by improving and maintaining patient health overall.

Though this digital era with its EMRs, population health management, and trends towards all-evidence-based practices has imbued our field of medicine with some challenges and consternations, gynecologists should embrace the opportunity provided by Well Women visits to address and digitally document all pertinent health issues from health maintenance to referrals and e-Prescribing, with an eye towards establishing enhanced communication and bonding with patients. It is for this reason, we believe, that ACOG reaffirmed the frequency of Well Women visits as an annual phenomenon. As for the indications for pelvic examination, ACOG recommends, and we affirm,

that the best course of action involves shared communication and decision making between patients and their gynecologists. In the spirit of offering the best care to our patients, we echo the USPSTF's call for more research on both the benefits and harms of pelvic examination at time of the annual Well Woman visit. This ongoing research and discussion is vital to the continual improvement of our field in the digital era, and to ensure that the risks of this epoch, with its emphasis on rigorous research and high-level evidence, do not unwittingly outweigh the benefits of excellent, frequent, and dependable patient care.

Bibliography

1. Siriwardena AN., *et al.* "Teaching and learning evidence-based medicine: cross-sectional survey investigating knowledge and attitudes of teachers and learners in primary and secondary care". *Education for Primary Care* 18.1 (2007): 45-57.
2. Boone E., *et al.* "Discontent and Confusion: Primary Care Providers' Opinions and Understanding of Current Cervical Cancer Screening Recommendations". *Journal of women's health (2002)* 25.3 (2016): 255-262.
3. Well Women Visit. "Committee Opinion. The American College of Obstetricians and Gynecologist. 534 (2012): Reaffirmed 2016.
4. *Cancers Facts and Figures 2016.*
5. Lee Y and Lin JL. "Do patient autonomy preferences matter? Linking patient-centered care to patient-physician relationships and health outcomes". *Social Science & Medicine* 71.10 (2010): 1811-1818.
6. Edelman A., *et al.* "Pelvic Examination". *New England Journal of Medicine* 356 (2007): e26.
7. Qaseem A., *et al.* "Screening Pelvic Examination in Adult Women: A Clinical Practice Guideline from the American College of Physicians". *Annals of Internal Medicine* 161.1 (2014): 67-72.
8. Draft Recommendation Statement. Gynecological Conditions: Screening with the Pelvic Examination (2016).
9. Roni Caryn Rabin. "Pelvic Exams May Not Be Needed". *Well* (2016).
10. Ariana Eunjung Cha. "The days of the dreaded annual pelvic exam for women may be numbered" *The Washington Post* (2016).
11. Lentz GM., *et al.* "A comprehensive women's health care center: Are gynecologists offering primary care?" *American Journal of Obstetrics and Gynecology* 194.6 (2006): 1660-1666.
12. Morgan MA., *et al.* "Well-woman care among Obstetrician-Gynecologists: opportunity for preconception care". *Journal of Maternal-Fetal and Neonatal Medicine* 25.6 (2012): 595-599.
13. Dunn LJ. "The obstetrician-gynecologist-Generalist, specialist, subspecialist?" *American Journal of Obstetrics and Gynecology* 1724 pt 1 (1995): 1188-1190.

Volume 3 Issue 4 August 2016

© All rights reserved by Takeko Takeshige., *et al.*