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Many of the topics featured in this newsletter are also covered from a patient perspective in *Women's Health Today*, the point-of-care magazine of the Women's Health Experience. We hope you'll find the publications fulfill their mission of working together to improve dialogue with your patients.



## HEART HEALTH AT MENOPAUSE:

# A matter of timing and risk

**Wulf Utian, MD, PhD**

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This companion article for your patients appears in *Women's Health Today*.

It is not surprising to encounter some confusion about all of the data published in the last few years on heart disease and postmenopausal hormone therapy (HT) in women. Now that a further analysis of results of the Nurses' Health Study, released earlier this year, was added to the findings of the Heart and Estrogen-Progestin Replacement Studies (HERS I and HERS II) and the Women's Health Initiative (WHI), a few points of clarification are required.

### Why timing matters

A window of opportunity for realizing potential cardiac benefits with HT emerged from the Nurses' Health Study. This is supported by other research, such as Tom Clarkson's animal studies at Wake Forest University Baptist Medical Center.

In essence, a different effect is seen when HT is started near the onset of menopause or at hysterectomy when the ovaries are removed than when it is started much later, as was the case in the WHI.

In the Nurses' Health Study, women without heart disease who began HT (estrogen therapy [ET] alone) at menopause had a significantly lower risk (30%) of coronary heart disease when compared with postmenopausal women who had never used hormones. Women who started either ET or estrogen/progestin therapy (EPT) at

least 10 years after menopause, had no significant reduction in risk. They never received the cardioprotective effects.

Research on this topic continues. One study exploring the theory that timing matters was published in the *Journal of Women's Health* in January of this year, and another in the February issue of the *Archives of Internal Medicine*. Two more clinical trials in the United States and Finland are underway.

### How do you define risk?

An important factor to consider in all of these studies is relative risk. The WHI publications were misleading when they extrapolated the relative risk results of their study, which was conducted in an older population (mean age 63), to a younger population (mean age 51) in which the prevalence of cardiac disease is lower. By speaking only of relative risk, the WHI investigators seem to have exaggerated the potential risk and caused a great deal of fear.

The North American Menopause Society defines relative risk as "the incidence in those exposed divided by the incidence in those not exposed." It is a comparative measure of one group against another. Absolute risk, on the other hand, is the risk anyone would incur in a period of 1 year. In study

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# Practical Strategies in WOMEN'S HEALTH

The clinical newsletter of the Women's Health Experience

Presented by the **FOUNDATION FOR FEMALE HEALTH AWARENESS**  
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## A MESSAGE FROM THE FOUNDER



**It wasn't very long ago** that the results of the first Heart and Estrogen-Progestin Replacement Study (HERS) revealed the effect of hormones on women's heart health. The finding that

hormones didn't seem to protect women from coronary heart disease was surprising at the time, and made us begin to think of heart disease in women in a new way. Since then, results from the Women's Health Initiative have provided further data on heart health—and added to the confusion. In this issue of *Practical Strategies in Women's Health*, Wulf Utian, MD, tells how the intervening time to reflect on these results has influenced the current thinking on hormones and cardiac health in women.

We've given much thought to the mission of this newsletter and its companion consumer magazine, *Women's Health Today*, which is to enhance the dialogue between physicians and patients. An essential element of fostering good communication is the establishment of trust. To build this foundation, patients must feel that they are viewed as individuals with particular needs and concerns, no matter what the diagnosis. Going forward, we'll include articles that reveal ways to accomplish this end. In this issue, Andrew Brill, MD, shows us how he relates to a patient who requires a hysterectomy, and Barbara Levy, MD, demonstrates her rapport with a patient who has fibroid tumors.

You'll also read about a recommended way to thoroughly evaluate pelvic organ prolapse that is ripe for outcomes studies, and about the dilemma of properly diagnosing vaginitis in an era of over-the-counter medications.

We hope you enjoy this issue of *Practical Strategies*, and wish you and your patients good partnerships for better health.

### Mickey Karram, MD

Co-Founder, Foundation for Female Health Awareness

Dr. Karram and his wife, Mona, are founders of the Women's Health Experience, the flagship program of the Foundation for Female Health Awareness. The Foundation is a nonprofit organization dedicated to educating women on all aspects of their health and funding unbiased gender-specific medical research.

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*Practical Strategies in Women's Health* is published four times a year by Dowden Health Media, 110 Summit Avenue, Montvale, NJ 07645, in conjunction with the Foundation for Female Health Awareness, PO Box 43028, Cincinnati, OH 45243. © 2005 Foundation for Female Health Awareness and Dowden Health Media, Inc. All rights reserved.

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# Putting hysterectomy in perspective



This companion article for your patients appears in *Women's Health Today*.

## THE PATIENT

**Mrs B is a 51-year-old woman who is educated and well informed. She has already consulted 2 other physicians, one of whom is recognized for expertise in alternative hysterectomies. For years she has known she has fibroids, but now she has pelvic discomfort and prolonged menses. The cosmetic effect of a bulging abdomen, coupled with urinary symptoms with pressure on the bladder, have become intolerable. She says she is ready to find relief and wants to know what her alternatives are.**

This patient is a fairly typical candidate for hysterectomy as a result of fibroid tumors. During our first appointment I will assess her symptoms and find out what she understands about fibroids. But there's a larger global issue I'm going to consider and develop in that first patient interview... and that's language.

## THE DIALOGUE

When I say the word "hysterectomy" and my patient says the word "hysterectomy," we are not necessarily talking about the same thing. It is not just the physical reality of the surgery that informs our discussion; it is also the experiences she has had or heard about. Hysterectomy is a word with very negative attributes. One friend may tell another that her sex life was ruined by hysterectomy, and that she feels permanently disfigured. Or a mother may tell a daughter that her hysterectomy rapidly propelled her into a horrible menopause and severe depression.

Ascribe these collective messages to the word "hysterectomy" and who would want to undergo such a procedure? So, I attempt to determine what the word means to *this* patient. Is it bleeding, pain, cosmetics, sexual dysfunction, or fear that something more serious is wrong? Then, I get to the heart of the matter. "What is it that

upsets you about hysterectomy?" Once I clarify the perceptions behind the word, I can reaffirm what I know to be true and demystify the preconceptions the patient brought with her.

## Explaining the options

After listening to her reply, we talk about the variations of hysterectomy: abdominal, vaginal, laparoscopic, and the variants of laparoscopic procedures. We go over the options and how they affect the organs: the cervix, the fundus, the tubes, and the ovaries. It is very helpful to approach this like a puzzle or a mix-and-match concept. The patient can put the pieces together in a way that suits her individual concerns.

Like many patients, Mrs. B wants to keep her ovaries, even though she understands that taking them out could reduce her risk for cancer.<sup>1,2</sup> The decision to preserve her cervix is emotional, not medical. Current information does not demonstrate health benefits.<sup>3,4</sup> But the idea of keeping her cervix addresses her fears and puts a certain measure of control back into her hands. So, together we decide to let the punishment appropriately fit the "crime." She suffers from fibroids. They inhabit the top of her uterus; therefore her cervix has nothing to do with her symptoms. It can stay.

For some women, the concern is

for the uterus itself, either because they believe their femininity and sexuality are associated with this organ, or because it is conceptually unacceptable to them to lose it. If a woman believes she will become less sexually desirable to a man if she has a hysterectomy, this has to be addressed.

Now, we discuss undergoing surgery as an outpatient with small incisions through laparoscopy, and Mrs. B's perception of this experience is radically altered. It has been my experience that the women who are most vehemently against hysterectomy at the outset become interested in undergoing corrective surgery for their symptoms when they understand that they can avoid a big abdominal incision and can choose to retain their ovaries, tubes, and cervix.

The vaginal route is always preferred in the context of recovery and complications. However, it is seldom offered because there are very few surgeons who are skilled at doing advanced vaginal surgery. Most surgeons opt for an abdominal approach, though it is the most invasive and complicated kind of surgery. In my opinion, it is in the patient's best interests to pursue the most minimally invasive approach; if not vaginal, then laparoscopic. When we can do it laparoscopically, abdominal hysterectomy then becomes an unacceptable alternative.

Making Mrs B part of the process provides her with a sense of ownership in the decision. Giving her all of the critical pieces of information and the time to process them lets her achieve intellectual and emotional comfort with her choice to have a hysterectomy. And it gives me, as her physician, a sense of accomplishment in having served as her partner in the decision-making.

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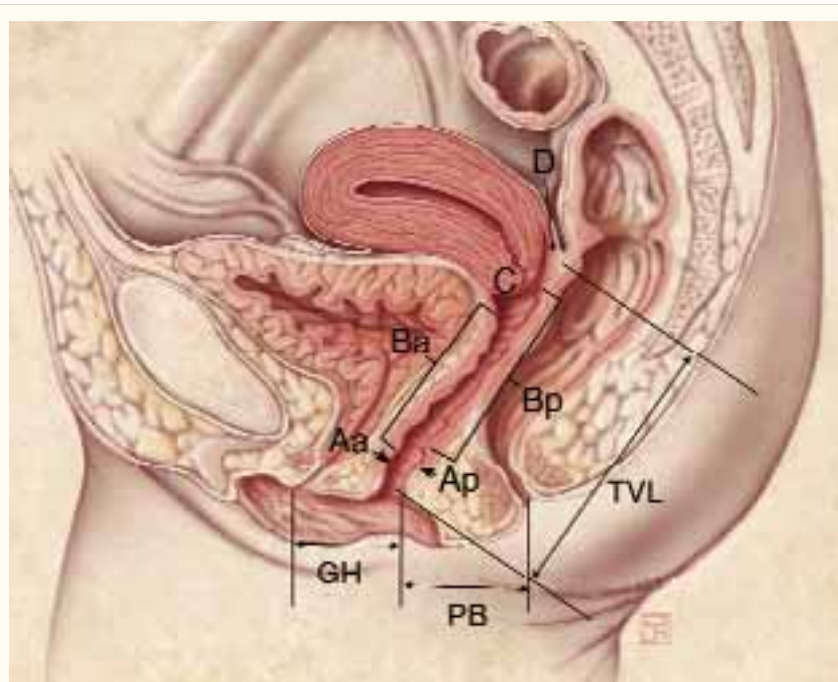


This companion article for your patients appears in *Women's Health Today*.

# Simple diagnostic procedures for pelvic organ prolapse

**A**s more women maintain active lifestyles into their later years, we are seeing an increase in the diagnosis of pelvic organ prolapse. Clinicians can accurately measure the extent of prolapse and properly stage their patients during an office visit with minimal equipment. Some patients will need referrals to specialists for surgical correction.

Currently, experts believe women with prolapse are genetically predisposed to the disorder, though no genetic marker has been identified. Further, it is thought that the condition is triggered primarily by childbirth damage to the pelvic muscles and nerves. This is most frequently associated with a large baby or a forceps delivery; episiotomy may also be a contributing factor. The natural wear and tear of aging, lifting, straining, and extended standing contribute further by increasing the pressure of the organs on the sagging pelvic floor.



## POPQ sites for evaluation

### The 6 POPQ sites measured in relation to the zero point:

- Aa:** The midline of the anterior vaginal wall 3 cm from the hymen
- Ba:** The most dependent position on the anterior vaginal wall between point Aa and the vaginal cuff or anterior vaginal fornix.
- C:** The cervix or vaginal cuff
- Ap:** The midline of the posterior vaginal wall 3 cm from the hymen
- Bp:** The most dependent position on the posterior vaginal wall between Ap and the vaginal cuff or posterior fornix
- D:** The posterior fornix

### Three other measurements include:

- GH:** The genital hiatus from the midportion of the urethral meatus to the posterior margin of the genital hiatus

**PB:** The perineal body between the posterior margin of the general hiatus and the midportion of the anus

**TVL:** The total vaginal length to the greatest depth of the vagina

### Staging for each compartment (anterior, apex, posterior) is based on these measurements:

- Stage 0:** No prolapse. Points Aa, Ap, Ba and Bp are all at -3 cm and point C or D are within 2 cm of TVL
- Stage I:** The most distal portion of the prolapse is >1 cm proximal to the level of the hymen
- Stage II:** The most distal portion of the prolapse is ≤1 cm proximal to or distal to the hymen
- Stage III:** The most distal portion of the prolapse is >1 cm below the hymen
- Stage IV:** Complete eversion is present

Questions your patients may ask you about...

## Pelvic Floor Prolapse

- I feel a tugging in my abdomen like something pulling. Could I have pelvic prolapse?
- If I have prolapse, can I simply wait and monitor my condition?
- My mother, my sister, and my grandmother all have prolapse. Should I have a C-section with my first baby?
- I've already had children. Is there anything I can do now to prevent prolapse?

**Melanie Witt, RN, CPC-OGS, MA**

Independent coding and documentation consultant  
Nielyn Consulting

## Typical symptoms and signs

If the prolapse is significant, the patient may have felt the cervix protruding past the hymen while squatting, straining, or showering. If it is mild, she may complain of pressure, a pulling sensation, a sense of a loose vagina, or may remark that she feels as if there is a tampon in place even when one is not present. Complaints may also stem from voiding problems such as incontinence or difficulty having a bowel movement.

In addition to conducting a detailed history, the clinician should ask about “splinting,” pressing the finger against the vagina or perineum to aid in voiding or fecal evacuation, as this points to posterior prolapse or rectocele. They should also ask about stress urinary incontinence, constipation, and anal incontinence.

## The POPQ examination

An assessment of the extent of the prolapse can be made using a pelvic organ prolapse quantification (POPQ) examination (Figure). In 1996, the International Continence Society introduced this standardized methodology. Though well established in research studies, it is not widely used in clinical practice. Routinely adopting this methodology when prolapse is suspected is key to national standardization for study comparisons. Computerized medical records can include a template with the 9 POPQ measurements, or a form can be included in the written chart, to be completed by the clinician.

The POPQ system quantifies the location and extent of prolapse in relation to the hymen and replaces the less precise terminology of cystocele, rectocele, and enterocele. There are 6 sites that are measured in relation to the hymen ring, which is the zero point. If the sites are inside the hymen they are assigned a negative number; if outside, a positive number. A speculum can be used to identify the sites and any appropriate tool marked in centimeters can easily be used for accurate measurements. Vaginal speculums are available with adjustable blades that cut the time of POPQ evaluations and reduce patient discomfort.<sup>1</sup>

Another critical component of the evaluation is a record of postvoid residual volume. This can be determined with ultrasound or catheter after office cystometry. The patient should also be tested with a full bladder for stress incontinence with the prolapsed organs lifted up to determine whether the prolapse is causing or preventing incontinence.

Patient response to a diagnosis of prolapse will be as different as personality. Some will wait until they are in Stage III or IV before they want corrective surgery. Those with mild prolapse will often agree to try Kegel exercises. Some will want a pessary, while others prefer immediate surgical correction. Physicians should inform patients of the high rate of recurrence and the possibility of repeat surgeries.

Older patients should be counseled that the vaginal route to surgical correction may be preferred over the abdominal approach due to reduced complication rates and significantly better recovery times. For younger patients, an abdominal approach may provide a longer-lasting correction. Though controversial, clinicians may wish to counsel pregnant patients with a family history of prolapse of the hypothesis that C-sections may reduce the incidence of future prolapse.

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## ► What is the best way to code low-risk HPV?

Greta, 42, undergoes cervical sampling by the Papanicolaou (PAP) test and human papillomavirus (HPV) test. The latter is positive for low-risk HPV types.

**Code 795.09**, other abnormal PAP smear of cervix and cervical HPV, has been revised slightly. The example of when to assign this code now reads “cervical low-risk human papillomavirus (HPV) DNA test positive.”

**SIMPLER WORDING:** This revision has simplified the wording of the example, clarifying its use, and does not change how the code is reported.

## ► Which codes for same-day multiprocedures?

“I need CPT codes for the following surgical procedures performed on 1 patient on the same day: transvaginal hysterectomy, anterior pelvic floor reconstruction with Pelvicol graft tissue, posterior colporrhaphy, enterocele repair, and a bilateral vaginal vault suspension with the IVS tunneler system.”

This type of multifaceted surgery can be coded in several different ways, but you need to be aware of the relative value combinations you may come up with for the different options and the reduction that is applied by the payer when more than 2 procedures are reported on 1 patient on the same day.

**YOU HAVE 2 CODING OPTIONS HERE:**

### OPTION 1

- **58270**-Vaginal hysterectomy with enterocele repair
- **57260-51**-Anterior and posterior (A&P) repair
- **57282-51**-Vaginal vault suspension
- **57267**-Pelvicol graft tissue (no modifier because this is a CPT “add-on” code)

### OPTION 2

- **58260**-Vaginal hysterectomy
- **57265-51**-A&P with enterocele repair
- **57282-51**-Vaginal vault suspension
- **57267**-Pelvicol graft tissue

Each option lists the most extensive procedure first, followed by the additional procedures with decreasing relative-value units. To decide which coding option is better you will need to know the payer allowables for each and what reduction, if any, the payer applies to the additional procedures. You would also have to be aware of any procedure bundles that are applied by your payer that might be different from those developed by Medicare. If you assumed this payer went by the Medicare relative-value system and a 50% reduction for the second and third procedures (the “add-on” should not be discounted by the payer as it is valued based solely on the intraoperative portion for that procedure), the second option would be marginally better.

# Assessing the emotional toll of fibroids



This companion article for your patients appears in *Women's Health Today*.

## THE PATIENT

**Ms A has heavy bleeding and anemia. She is 33, is not sexually active, and has never had children. She has flooding periods every month, has been to several physicians, and wants a hysterectomy immediately. An ultrasound shows 5 fibroids.**

This patient is feeling hopeless, emotionally overwhelmed, and so fed up with bleeding that she is ready for a solution that may not be in her best interests. I want to offer her the best possible advice, so I tell her there is good news and bad news.

## THE DIALOGUE

"We know why you're bleeding," I say. "You have some benign noncancerous growths called fibroids that are very common." I use the word "fibroids" instead of "tumors" intentionally, so she has less reason to be alarmed.

Still, she is afraid. She has seen the ultrasound, and strongly believes the fibroids need to be removed. Now is the time for me to get to know my patient better. I wait for her to feel comfortable talking about her fears and her emotions. I listen. I reassure her that it is not cancer, that she is not going to die.

## Patient concerns

We look at the set of problems before us: bleeding, contraception, future pregnancies, physical bulk, cosmetics, pain, and incontinence. I try to deter-

mine what symptoms are the most bothersome, because that will guide our discussion of treatment.

When we begin to talk about options, I use an algorithm that starts with treating only the anemia. For this relatively young patient, future pregnancy is a major branch in the decision tree because if this is important to her our treatment options are limited.

We talk about hormonal suppression that can be accomplished nonsurgically with the use of a hormone-releasing intrauterine device, or systemically with powerful medications that turn off the body's natural hormones. We also discuss surgical treatment with myomectomy, both abdominal and laparoscopic. I tell her it is often preferable to avoid surgery as long as possible because of the resultant scar tissue and the high rate of fibroid recurrence. Ideally, surgery would be done 4 to 6 months prior to the time she would like to conceive. This timing allows her uterus to heal, and also allows a window of opportunity to conceive before fibroids might recur.

## A review of options

My philosophy is to review every option, so next we talk about treatments that may end fertility. I take a social history and try to figure out why Ms A wants a hysterectomy. I share data that show a high risk for women younger than 35 who chose this

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Questions your patients may ask you about...

## Fibroids

- Do uterine fibroids lead to cancer?
- How large are my fibroids?
- What happens if I decide not to treat them?
- Should I have a hysterectomy, or are other alternatives appropriate for me?
- How will my quality of life be affected by my choice of treatment?

**Uterine artery embolization (UAE)** is not yet an option for young fertile women in this country. Looking at results in Europe and Canada, we see fertility statistics that are promising. Although many of my patients are distressed by the thought of their bodies reabsorbing dead tissue, there are times when this method is appropriate. For example, one patient who had significant complications during a prior myomectomy (including a blood transfusion, bowel obstruction, and adhesions) was a good candidate.

Another patient for whom this would be a good choice is morbidly obese, hypertensive, diabetic, and hemiparetic after a stroke. She is also a Jehovah's Witness who desires non-surgical treatment. This patient chose a UAE with specialized fluoroscopy for morbidly obese patients. Her bleeding stopped almost immediately.

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# The dilemma of diagnosing vaginal infections

**Q** Many women are self-treating for yeast infections. Is this dangerous?

**A** No, not if they in fact have candidiasis and follow up with a visit to their physician if the treatment is not successful. However, patients do not do a good job of self-diagnosing yeast. In one study, about 30% of women buying over-the-counter yeast medications did not have the condition.<sup>1</sup> Obviously this raises concerns that other conditions are going untreated.

**Q** There are now several over-the-counter tests for elevated pH. One easy-to-use version tests pH and dilution of vaginal discharge. These can help women tell if they have a bacterial infection or trichomoniasis rather than a yeast infection. Are these useful tools for women?

**A** I think this is a step in the right direction; but I find it ironic that patients will be using pH kits when many physicians do not do the test themselves during an office visit. A pH test is the very first thing I do after taking an extensive history and physical examination, because it is going to eliminate or identify 2 of the 3 most common conditions for vaginitis; a bacterial infection or trichomoniasis.

**Q** What are the essential steps in differential diagnosis?

**A** The history is a critical phase of diagnosis. I ask about the onset of itching and what other things were going on. Was there a new sexual partner? Was she ill and taking antibiotics? Did she begin an exercise program? Also, how severe is the itching? Does it wake her up at night? Is it there every day or does it come and go? And, where is the itching? Does it extend to the anal or thigh areas? What kinds of products is she using and what are her personal hygiene habits? Does she douche? Is she diabetic or taking steroids? Has she received temporary relief from any treatment program? Then I move on to the examination, testing for elevated pH, a wet mount, and whatever other tests are appropriate.

**Q** What are the difficulties in diagnosing the cause of vaginitis?

**A** We were taught to make diagnosis by looking at secretions. In actuality, that is one of the most inaccurate methods.<sup>2,3</sup> Women come into my office saying, "I have been itching for 6 months and the creams my doctor gives me are not helping." Did her physician check for elevated pH? Did her physician do a wet mount and look at secretions under a microscope? If yeast is present, 40% of the time the wet mount does not show it. Given that failure rate and new yeasts that can grow in elevated pH, a speciated culture always should be sent out for laboratory confirmation.

**Q** What's the most common reason for misdiagnosis?

**A** Misdiagnosis is very common when there is more than one condition present. For instance, a combination of skin disease, yeast, and a reaction to a contactant. An elderly woman with a skin problem might also be diabetic, have atrophy from lost estrogen, and have a yeast infection. I had one case that took months to diagnose even with the help of a skin specialist. It was a patient with skin disease, herpes, and skin cancer.

**Q** When do patients visit a specialist for this problem?

**A** By the time patients with severe vaginitis come to my office, they are extremely upset and distraught by constant discomfort and itching. In some cases, they have seen dozens of physicians and they cannot understand why modern medicine has failed them, but I believe it has. In this country, our training in vulvovaginal disease is very limited, and as a result diagnostic failure in the field is far too high. We are taught to look for 3 kinds of vaginitis: yeast infections, bacterial infections and trichomoniasis. But we're seeing increases in human papilloma virus and herpes, new inflammatory vaginitis, and chronic yeast that is unresponsive to standard treatment.

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## A matter of timing and risk (Continued)

populations, the age at which relative risk changes is highly significant, as is the fact that the ages studied in these 3 trials varied greatly.

The World Health Organization has also defined risk, stating that an incidence of less than or equal to 1 in 1000 (or 10 in 10,000) events is rare and that an incidence of less than or equal to 1 in 10,000 events is very rare. Therefore, the level of risk for coronary heart disease demonstrated in the WHI (7 in 10,000) is in the area of rare.

Additionally, the degree of benefit of HT as regards osteoporosis and colon cancer would also fall into the category of rare, because the prevalence of those problems would be less common in the younger population of women than they would be in the older population.

The position statement, "Recommendations on estrogen and progestogen use in peri- and postmenopausal women," released by the North American Menopause Society in 2004, was recently revisited and found to be still valid. The primary reason for the use of ET and EPT continues to be the treatment of moderate-to-severe symptoms of menopause. Current recommendations with regard to the duration of use indicate that the guiding principle should be use of the lowest effective dose and time consistent with treatment goals. The decision to use HT for the lowering of long-term risks is still open to debate.

By speaking only of relative risk, the WHI investigators seem to have exaggerated the potential risk and caused a great deal of fear.

## Assessing the emotional toll of fibroids (Continued)

option to later regret the loss of fertility.<sup>1</sup> I won't refuse to do the surgery, but first I will get to know her very well over a period of time so that I can thoroughly understand her reasoning.

I tell my young patient about hand-assisted laparoscopy. I explain that I feel the uterus with my fingers and find every fibroid I can, mentioning that in one case I located 124, some tiny as fish eggs. This is reassuring to her, as she concludes that her 5 fibroids seem less serious in comparison. I explain that I then sew the uterus in four or five layers, preventing weak spots that might be likely to rupture during a future pregnancy or delivery.

Finally, we talk about some of the newer, less studied options such as MRI-guided ultrasound. And, we look at Lupron® or gonadotropin-releasing hormone agonists, often used as a bridge to menopause for older women, or to shrink fibroids prior to surgery. Obviously, some treatments are not the best for this patient, but the decision is a process and she needs to understand all the options. After thinking it over, she chose hormonal treatment to be followed by myomectomy and presurgical treatment with Lupron prior to pregnancy.

To be effective clinicians, we have to understand where each patient is coming from. What is her expectation for treatment? Are her perceptions correct? Are they unrealistic? Does she believe surgery is a miracle cure for bleeding, pelvic pain, incontinence, or a bad sex life? We have to help our patients understand what we can and cannot fix surgically and guide them as they choose an appropriate solution, including the choice to do nothing. And, most importantly, we have to listen.