GYN TOPICS FOR THE PRIMARY CARE PHYSICIAN

Shannon Connole DO

- BIRTH CONTROL
- PAP MANAGEMENT
- VAGINAL INFECTIONS

BIRTH CONTROL

Birth control

Estrogen/Progesterone
Will regulate menstrual cycles

- Birth control pills
  - most
- Birth control patches
  - Ortho Evra & Twirla
- Birth control vaginal rings
  - Nuvaring & Annovera

Progesterone only
May eliminate menstrual cycles

- Progesterone only pills
  - Micronor & Slynd
- Depo injection
- Nexplanon Implant
- Hormonal IUDs
  - Kyleena
  - Mirena
  - Liletta

Birth control

Pregnancy Prevention

- Prevent the ovaries from releasing an egg
- Changes in the cervical mucus: increase viscosity to decrease sperm mobility
- Thin the lining of the uterus/endometrium to prevent implantation
- Fertility returns to normal almost immediately after stopping most options

Noncontraceptive benefits

- Decreased risk of: ovarian and endometrial cancers, ectopic pregnancy, ovarian cysts, benign breast disease
- Improvement in acne
- Less-severe dysmenorrhea
- Reduction in androgen production caused by polycystic ovary syndrome
- Reduction in heavy menstrual bleeding
- Relief from premenstrual syndrome (PMS/PMDD)
- Menstrual regulation
- Treatment for perimenopause

Estrogen/Progesterone Pills

- Most use between 20 and 35 micrograms of estrogen
  - Some have as little as 10 micrograms of estrogen: Lo Loestrin
  - Main difference between pills is the progesterone
- Combination pills are either monophasic or multiphasic
  - Monophasic pills deliver an even level of hormones throughout the month.
  - Multiphasic ones have slightly different levels of hormones in active pills. They mimic normal hormonal changes that happen during the menstrual cycle
- Extended-cycle combination pill
  - Packaged for 3 months at a time with the placebo week occurring every 3rd month.
- About 91-94% effective for pregnancy prevention
- Needs to be taken daily about the same time of the day within a few hours.
- Need about 3 months on any pill to see how it is going to regulate the menstrual cycle

Estrogen/Progesterone Pills

- Teens:
  - Loestrin Fe 1/20
  - Apri
  - Minastrin Fe – chewable
- Perimenopause:
  - Loestrin 1.5/30
  - Apri
  - Seasonique
- Acne:
  - Ortho-Tri Cyclen – can cause mid-cycle spotting
  - Yaz

Birth Control Patch

- Works the same way as pills due to the estrogen/progesterone
- Weekly use rather than daily use
  - Patch free week is menses week
- About 91-94% effective for pregnancy prevention
- Can place on buttock, upper outer arm, lower abdomen

Birth Control Ring

- Works the same way as pills due to the estrogen/progesterone
- Monthly use
  - Ring free week is menses week
- About 91-94% effective for pregnancy prevention
- Does not increase the risk of vaginal infections
- Can remain in place for any activity
  - Can be out for 1 hour for intercourse and still be effective for pregnancy prevention

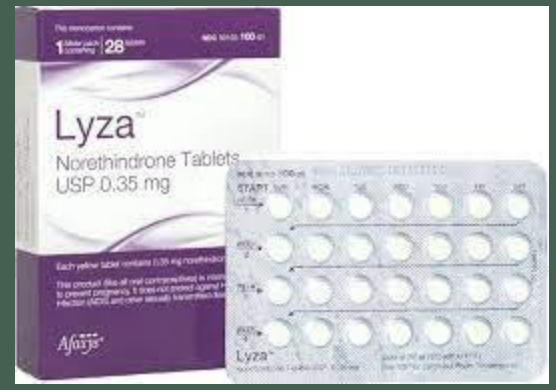
- NuvaRing was the first vaginal ring approved for use and requires use of a new ring each month.
- Annovera is a contraceptive vaginal ring that can be used for an entire year, it should be removed for one week each month.

Progesterone Only Contraception

- Can be used in ANY patient: any age, any medical problem
- The progesterone thickens cervical mucus and thins the endometrium
- Progesterone only contraception suppresses ovulation, but **NOT** consistently
- 91-99.5 % effective for pregnancy prevention depending on the type of contraception
- Will create amenorrhea in 50% of patients

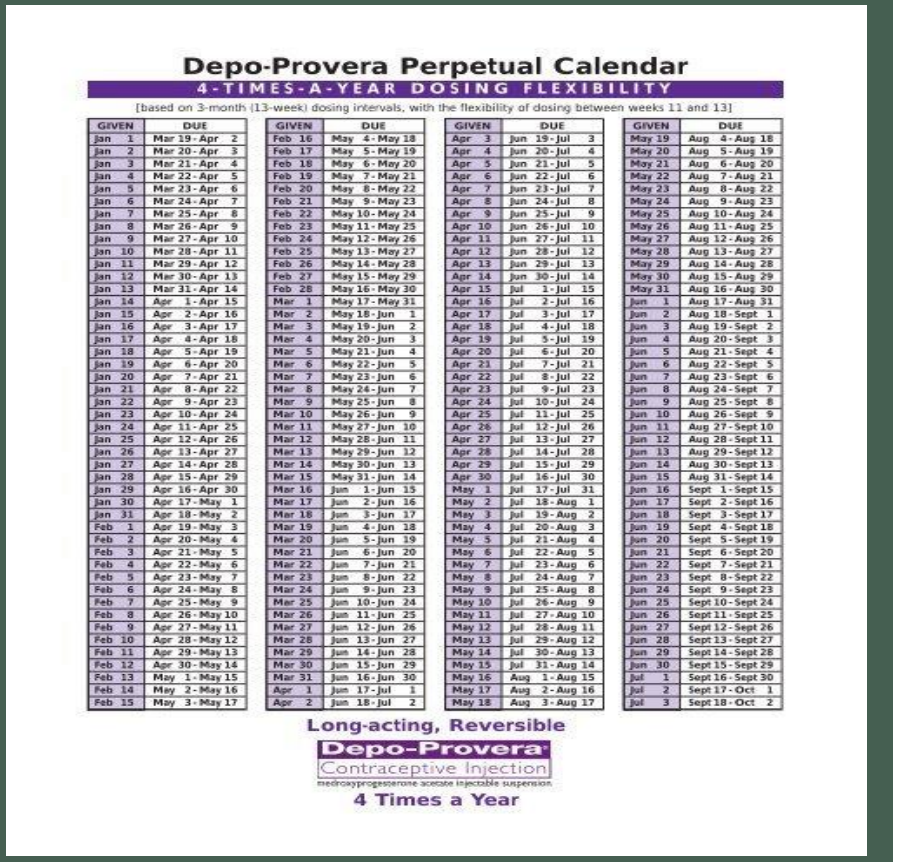
Progesterone Only Pills (Mini Pill)

- Progesterone only pills
  - Micronor is continuous – no placebo week
    - Norethindrone
  - Slynd has placebo week
    - Drosperinone – slight blood clot risk compared to other progesterones
- Must take at the same time daily – more important then combined OCPs
- Can be used in breastfeeding mothers without effecting milk supply
- Treatment of choice for dermatitis that seems to be related the menses
- Breakthrough bleeding & PMS/menopausal symptoms can occur



Depo Provera Injection

- Medroxyprogesterone acetate 150 mg
- Given IM q 3 months (Depo calendar)
- 96% effective for pregnancy prevention
- Suppresses ovulation more often
- No longer a 2 year maximum time indication
- Does cause 5% reversible bone loss in teens
- Most likely of all birth control to cause weight gain
  - 5 lbs per year average
- Most likely to cause a delay in return of fertility
  - Depends on continuous time of use



Depo-Provera Perpetual Calendar

4-TIMES-A-YEAR DOSING FLEXIBILITY

[based on 3-month (13-week) dosing intervals, with the flexibility of dosing between weeks 11 and 13]

GIVEN	DUE
Jan 1	Mar 19 - Apr 2
Jan 2	Mar 20 - Apr 3
Jan 3	Mar 21 - Apr 4
Jan 4	Mar 22 - Apr 5
Jan 5	Mar 23 - Apr 6
Jan 6	Mar 24 - Apr 7
Jan 7	Mar 25 - Apr 8
Jan 8	Mar 26 - Apr 9
Jan 9	Mar 27 - Apr 10
Jan 10	Mar 28 - Apr 11
Jan 11	Mar 29 - Apr 12
Jan 12	Mar 30 - Apr 13
Jan 13	Mar 31 - Apr 14
Jan 14	Apr 1 - Apr 15
Jan 15	Apr 2 - Apr 16
Jan 16	Apr 3 - Apr 17
Jan 17	Apr 4 - Apr 18
Jan 18	Apr 5 - Apr 19
Jan 19	Apr 6 - Apr 20
Jan 20	Apr 7 - Apr 21
Jan 21	Apr 8 - Apr 22
Jan 22	Apr 9 - Apr 23
Jan 23	Apr 10 - Apr 24
Jan 24	Apr 11 - Apr 25
Jan 25	Apr 12 - Apr 26
Jan 26	Apr 13 - Apr 27
Jan 27	Apr 14 - Apr 28
Jan 28	Apr 15 - Apr 29
Jan 29	Apr 16 - Apr 30
Jan 30	Apr 17 - May 1
Jan 31	Apr 18 - May 2
Feb 1	Apr 19 - May 3
Feb 2	Apr 20 - May 4
Feb 3	Apr 21 - May 5
Feb 4	Apr 22 - May 6
Feb 5	Apr 23 - May 7
Feb 6	Apr 24 - May 8
Feb 7	Apr 25 - May 9
Feb 8	Apr 26 - May 10
Feb 9	Apr 27 - May 11
Feb 10	Apr 28 - May 12
Feb 11	Apr 29 - May 13
Feb 12	Apr 30 - May 14
Feb 13	May 1 - May 15
Feb 14	May 2 - May 16
Feb 15	May 3 - May 17
Feb 16	May 4 - May 18
Feb 17	May 5 - May 19
Feb 18	May 6 - May 20
Feb 19	May 7 - May 21
Feb 20	May 8 - May 22
Feb 21	May 9 - May 23
Feb 22	May 10 - May 24
Feb 23	May 11 - May 25
Feb 24	May 12 - May 26
Feb 25	May 13 - May 27
Feb 26	May 14 - May 28
Feb 27	May 15 - May 29
Feb 28	May 16 - May 30
Mar 1	May 17 - May 31
Mar 2	May 18 - Jun 1
Mar 3	May 19 - Jun 2
Mar 4	May 20 - Jun 3
Mar 5	May 21 - Jun 4
Mar 6	May 22 - Jun 5
Mar 7	May 23 - Jun 6
Mar 8	May 24 - Jun 7
Mar 9	May 25 - Jun 8
Mar 10	May 26 - Jun 9
Mar 11	May 27 - Jun 10
Mar 12	May 28 - Jun 11
Mar 13	May 29 - Jun 12
Mar 14	May 30 - Jun 13
Mar 15	May 31 - Jun 14
Mar 16	Jun 1 - Jun 15
Mar 17	Jun 2 - Jun 16
Mar 18	Jun 3 - Jun 17
Mar 19	Jun 4 - Jun 18
Mar 20	Jun 5 - Jun 19
Mar 21	Jun 6 - Jun 20
Mar 22	Jun 7 - Jun 21
Mar 23	Jun 8 - Jun 22
Mar 24	Jun 9 - Jun 23
Mar 25	Jun 10 - Jun 24
Mar 26	Jun 11 - Jun 25
Mar 27	Jun 12 - Jun 26
Mar 28	Jun 13 - Jun 27
Mar 29	Jun 14 - Jun 28
Mar 30	Jun 15 - Jun 29
Mar 31	Jun 16 - Jun 30
Apr 1	Jun 17 - Jul 1
Apr 2	Jun 18 - Jul 2
Apr 3	Jun 19 - Jul 3
Apr 4	Jun 20 - Jul 4
Apr 5	Jun 21 - Jul 5
Apr 6	Jun 22 - Jul 6
Apr 7	Jun 23 - Jul 7
Apr 8	Jun 24 - Jul 8
Apr 9	Jun 25 - Jul 9
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Apr 14	Jun 30 - Jul 14
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Apr 16	Jul 2 - Jul 16
Apr 17	Jul 3 - Jul 17
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Apr 25	Jul 11 - Jul 25
Apr 26	Jul 12 - Jul 26
Apr 27	Jul 13 - Jul 27
Apr 28	Jul 14 - Jul 28
Apr 29	Jul 15 - Jul 29
Apr 30	Jul 16 - Jul 30
May 1	Jul 17 - Jul 31
May 2	Jul 18 - Aug 1
May 3	Jul 19 - Aug 2
May 4	Jul 20 - Aug 3
May 5	Jul 21 - Aug 4
May 6	Jul 22 - Aug 5
May 7	Jul 23 - Aug 6
May 8	Jul 24 - Aug 7
May 9	Jul 25 - Aug 8
May 10	Jul 26 - Aug 9
May 11	Jul 27 - Aug 10
May 12	Jul 28 - Aug 11
May 13	Jul 29 - Aug 12
May 14	Jul 30 - Aug 13
May 15	Jul 31 - Aug 14
May 16	Aug 1 - Aug 15
May 17	Aug 2 - Aug 16
May 18	Aug 3 - Aug 17
May 19	Aug 4 - Aug 18
May 20	Aug 5 - Aug 19
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May 23	Aug 8 - Aug 22
May 24	Aug 9 - Aug 23
May 25	Aug 10 - Aug 24
May 26	Aug 11 - Aug 25
May 27	Aug 12 - Aug 26
May 28	Aug 13 - Aug 27
May 29	Aug 14 - Aug 28
May 30	Aug 15 - Aug 29
May 31	Aug 16 - Aug 30
Jun 1	Aug 17 - Aug 31
Jun 2	Aug 18 - Sept 1
Jun 3	Aug 19 - Sept 2
Jun 4	Aug 20 - Sept 3
Jun 5	Aug 21 - Sept 4
Jun 6	Aug 22 - Sept 5
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Jun 27	Sept 12 - Sept 26
Jun 28	Sept 13 - Sept 27
Jun 29	Sept 14 - Sept 28
Jun 30	Sept 15 - Sept 29
Jul 1	Sept 16 - Sept 30
Jul 2	Sept 17 - Oct 1
Jul 3	Sept 18 - Oct 2

Long-acting, Reversible

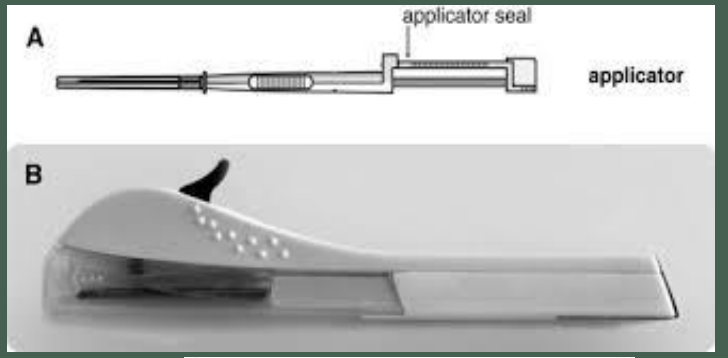
Depo-Provera®

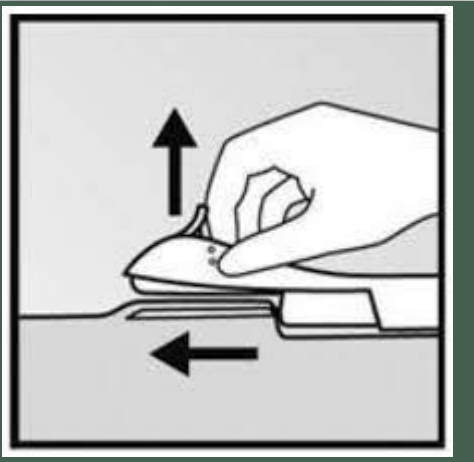
Contraceptive Injection

medroxyprogesterone acetate injectable suspension

4 Times a Year

Nexplanon Implant





- Etonogestrel 68 mg
- LARC: 3 years
- Suppresses ovulation more often
  - **99%** effective for pregnancy prevention
- Flexible plastic rod about the size of a matchstick that is placed under the skin of the upper nondominant arm (21 gauge needle)
- Contraceptive implants are radio opaque/can be seen on X-rays
  - Norplant was not & had multiple rods
- Can be removed at any time
- Quick return to fertility – within 1 month
- Breakthrough bleeding/spotting is the most common complaint
  - can often be managed with a month of combined OCPs

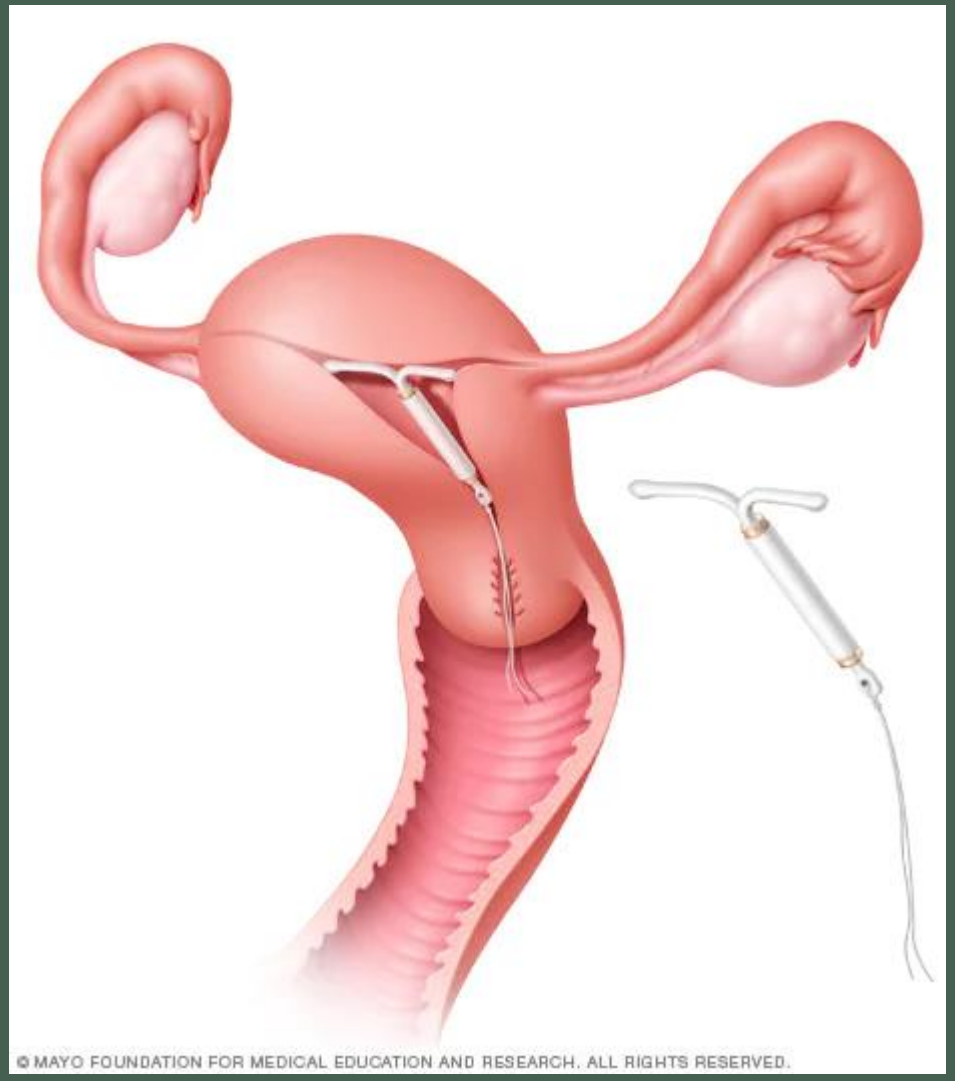
Progesterone Intrauterine Device

- LARC: 5-8 years depending on the device
- Suppresses ovulation more often
  - **99%** effective for pregnancy prevention
- Radio opaque/can be seen on X-rays
- Can be removed at any time
- Quick return to fertility – within 1 month
- Inconsistent ovulation suppression
  - Poor at ovarian cyst prevention
- No increased risk of pelvic infections
  - Treat but DO NOT have to remove
- Can be inserted IMMEDIATELY postpartum
  - Vaginal delivery or Cesarean

- Can be used to treat:
  - Heavy menstrual bleeding
  - Cramping or pain with periods
  - Endometriosis/adenomyosis
  - Endometrial hyperplasia
  - Fibroids
  - Anemia

- Rarely, insertion causes perforation of the uterus
- Rarely causes infertility

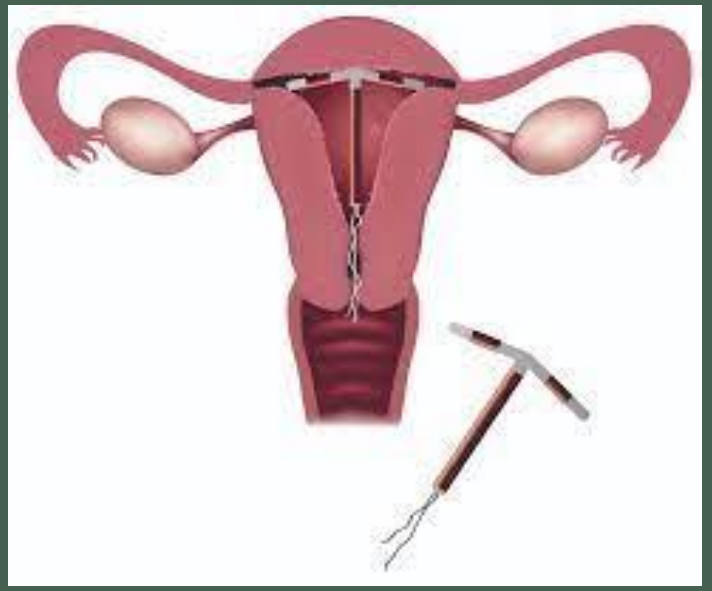
- Risk is higher when inserted during the 8 week postpartum time frame



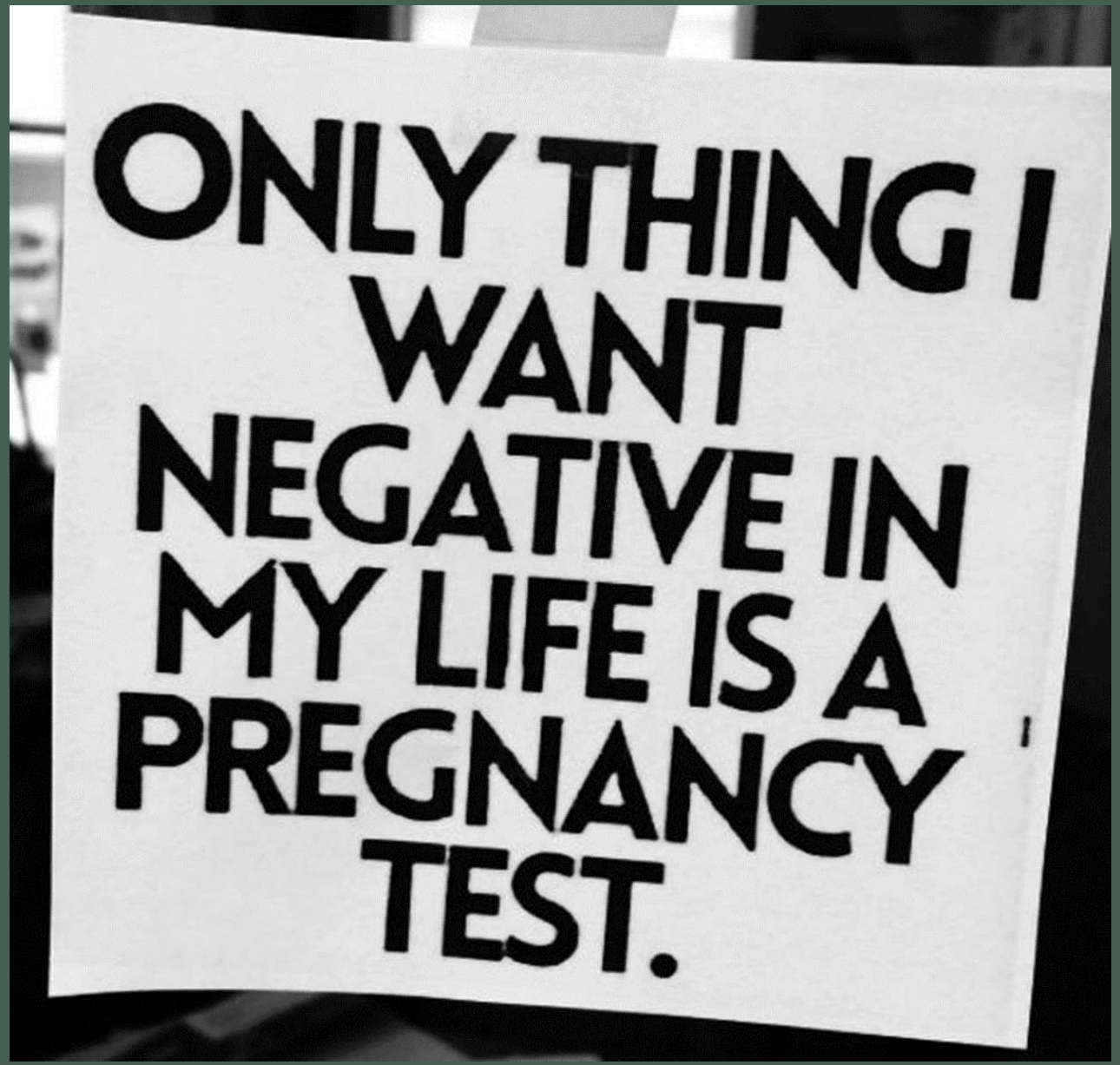
NAME	HORMONE	DOSE	APPROVED FOR
ParaGard	N/A, uses copper	N/A	10/12 years*
Mirena	levonorgestrel	20 mcg/day (52 mg total in the device)	5/7 years*
Liletta	levonorgestrel	18.6 mcg/day (52 mg total)	3/5 years*
Kyleena	levonorgestrel	17.5 mcg/day (19.5 mg total)	5 years
Skyla	levonorgestrel	14 mcg/day (13.5 mg total)	3 years

ParaGard Copper IUD

- Hormone free
  - No long term hormone benefits
    - Ovarian/uterine cancer reduction due to not suppressing ovulation
- Good for 10+ years
  - Immediate return of fertility
- Can be used for emergency contraception
  - inserted within 5 days after unprotected sex
- **99%** effective
  - Higher risk of ectopic compared to other IUDs
- Works by inflammation
  - Can make menses heavier/cramping




10:00
Friday, April 5
Would you rather wake up to this or a CRYING BABY!!
Snooze
slide to stop alarm


ONLY THING I WANT NEGATIVE IN MY LIFE IS A PREGNANCY TEST.

PAP SMEAR

WHAT YOU CAN WATCH & WHAT YOU SHOULD SEND

ASCCP GUIDELINES
(American Society for Colposcopy and Cervical Pathology)

- https://www.asccp.org/screening-guidelines
- https://www.asccp.org/management-guidelines

New Management Guidelines: 2019 Guidelines

- ASCCP Risk-Based Management Consensus Guidelines for abnormal cervical cancer screening
- The new iOS & Android mobile apps and the Web application
- The new guidelines use current and past results (and other factors) to create individualized assessments of a patient's immediate risk of precancer (CIN3+) or 5-year risk of progressing to precancer or cancer
- ASCCP endorses the ACOG Practice Advisory: Updated Cervical Cancer Screening Guidelines

Figure 2. Summary of Surveillance Thresholds

Return in 5 years	Return in 3 years	Return in 1 year
equivalent to general population with one negative HPV or co-test	similar to a negative screening cervical cytology (Pap test)	between colposcopy and 3-year return thresholds
≤0.1% CIN3+ risk at 5 years	0.2% -0.5% CIN3+ risk at 5 years	0.6% risk at 5 years to <4% immediate risk of CIN3+

- More conservative with abnormal PAPs
  - especially under the age of 30 yrs
  - likely will return to normal given time
    - given an immunocompetent patient

Figure 1. Summary of Risk-based Clinical Action Thresholds

CIN3+ risk Risk	Surveillance			Colposcopy	Treatment	
	Return in 5 years equivalent to general population with one negative HPV or co-test	Return in 3 years similar to a negative screening cervical cytology	Return in 1 year between colposcopy and 3-year return thresholds	Colposcopy Approximate risk of low grade to moderately abnormal results in a screening population (e.g. LSIL)	Colposcopy or Treatment Approximate risk of moderate to high risk results in a screening population (e.g. ASC-H)	Treatment preferred* Very high risk results (e.g. HSIL/ HPV 16+) *treatment without biopsy, see-and-treat
	≤0.1% at 5 years	0.2% -0.5% at 5 years	0.6% at 5 years to <4% immediate risk	4%-24% immediate	25%-49% immediate	≥50% immediate

Table 1. 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

Abbreviations: FDA, U.S. Food and Drug Administration; hrHPV, high-risk human papillomavirus testing.

*These recommendations apply to individuals with a cervix who do not have any signs or symptoms of cervical cancer, regardless of their sexual history or HPV vaccination status. These recommendations **do not apply** to individuals who are at high risk of the disease, such as those who have previously received a diagnosis of a high-grade precancerous cervical lesion. These recommendations also do not apply to individuals with in utero exposure to diethylstilbestrol or those who have a compromised immune system (eg, individuals with human immunodeficiency virus).

†Grade A denotes that "The USPSTF recommends the service. There is high certainty that the net benefit is substantial." A Grade D definition means that, "The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits." For more information on the USPSTF grades, see https://www.uspreventiveservicestaskforce.org/Page/Name/grade-definitions

‡Primary hrHPV testing is FDA approved for use starting at age 25 years, and ACOG, ASCCP, and SGO advise that primary hrHPV testing every 5 years can be considered as an alternative to cytology-only screening in average-risk patients aged 25–29 years.

§Adequate *negative prior screening test results* are defined as three consecutive negative cytology results, two consecutive negative cotesting results, or two consecutive negative hrHPV test results within 10 years before stopping screening, with the most recent test occurring within the recommended screening interval for the test used (1, 5).

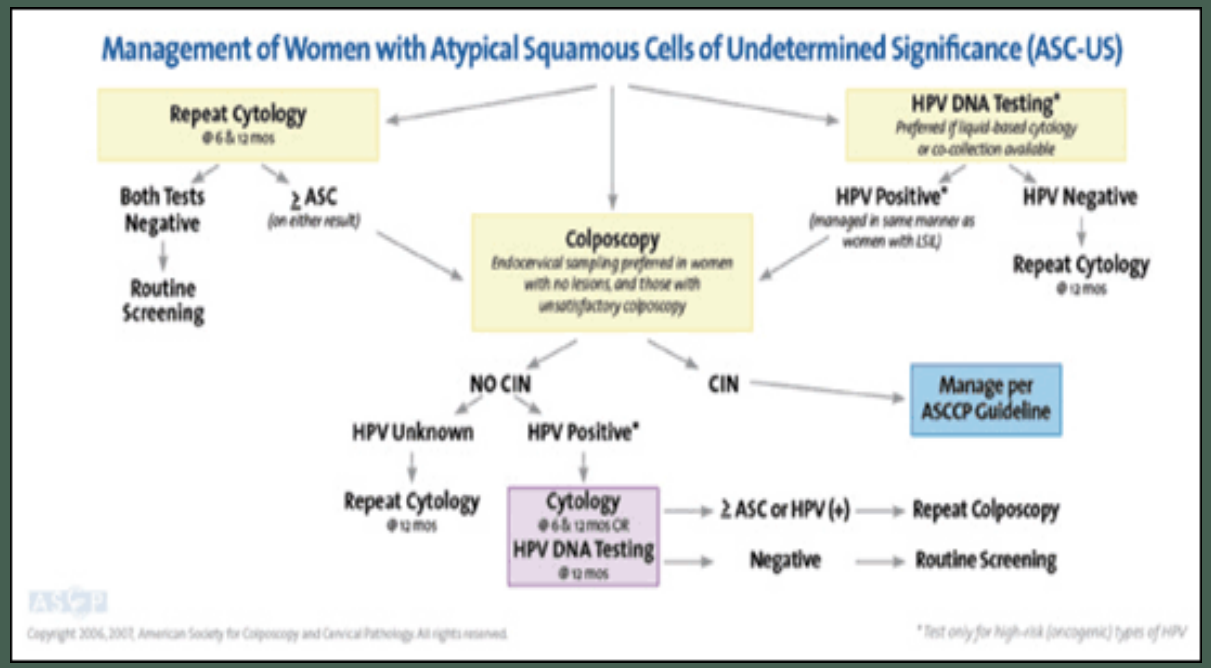
Data from Curry SJ, Krist AH, Owens DK, Barry MJ, Caughey AB, Davidson KW, et al. Screening for cervical cancer: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force. JAMA 2018;320:674–86. Available at: https://jamanetwork.com/journals/jama/fullarticle/2697704. Retrieved April 12, 2021.

- **Screening:**
  - Age less than 21 years: NO SCREENING
    - Doesn't matter number of partners or age of first intercourse
  - Age 21-29:
    - PAP alone every 3 years
    - ONLY do HPV screening if ASCUS or higher
  - Age 30-65:
    - PAP ONLY every 3 years
    - HPV high risk screening ONLY every 5 years
    - Cotesting (PAP & HPV) every 5 years
  - Age 65+:
    - None as long as they have never had HGSIL+
    - None if they have had 20+ consecutive years of negative screening
  - Hysterectomy regardless of age:
    - None as long as they have never had HGSIL+

What can you keep?

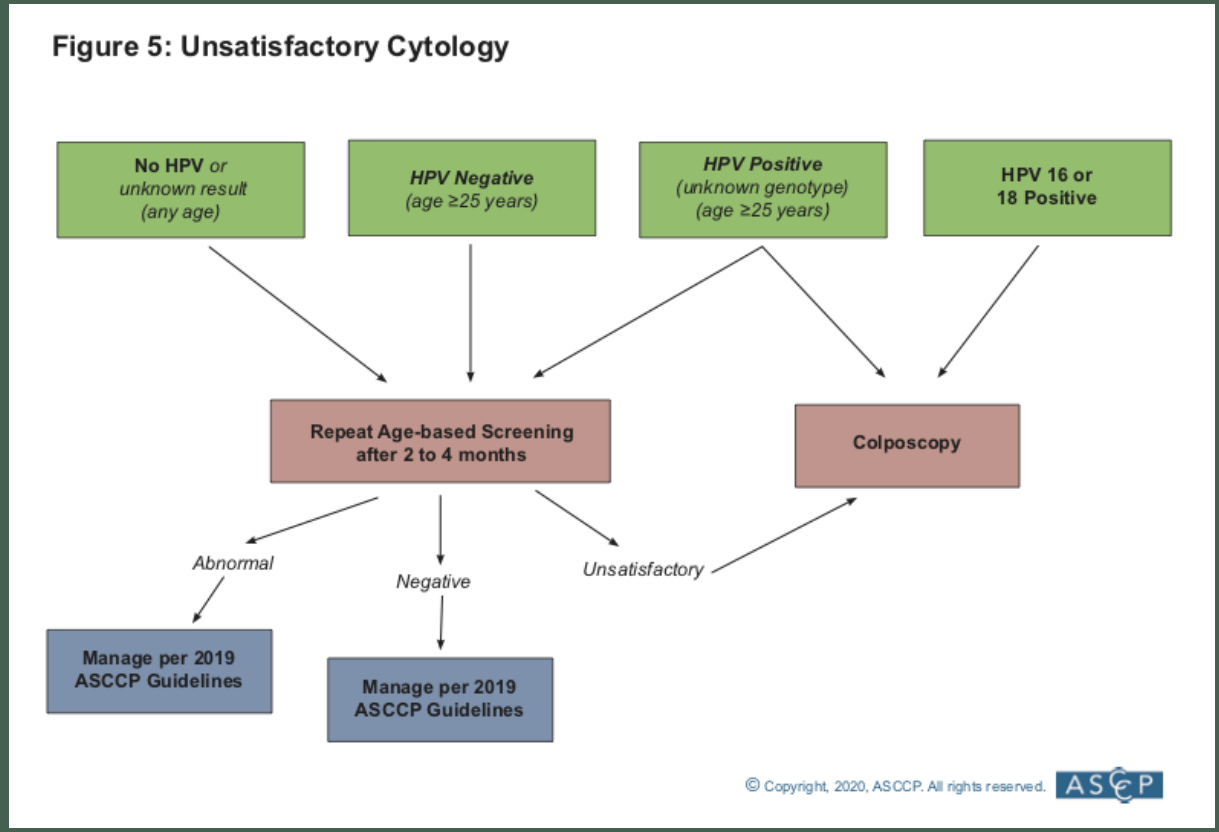
ASCUS PAPs

- ASCUS without HPV screening:
  - Order a reflex HPV – they will do it!
  - If no reflex HPV repeat in 1 year
- ASCUS with negative HPV:
  - Repeat PAP with HPV in 1 year
    - often due to vaginal infections
  - If positive for 2 consecutive years - send
- ASCUS with positive HPV:
  - Reasonable to send for +16/18
  - Reasonable to repeat in 1 year if + not 16/18
    - especially under 30 y/o



UNSATISFACTORY PAP

- These can be a bit more challenging
- Repeat after 2-4 months
  - Treat per results of repeat
  - If 2 consecutive unsatisfactory – SEND
    - Concern for abnormality



What to send

- LGSIL
- HGSIL
- ASC-H

- HIV patients need yearly PAPs

Pap Smear Test Result	21-24 Years of Age	25-29 Years of Age	≥ 30 Years of Age HPV Negative	≥ 30 Years of Age HPV Positive
Normal Pap Test Result	● Pap test every 3 years	● Pap test every 3 years	● Co-testing every 5 years o preferred ● Pap test every 3 years o acceptable	● Co-testing in 1 year o acceptable ● HPV typing o acceptable
ASC-US	● Pap test in 1 year o preferred ● Reflex HPV test o acceptable	● Pap test in 1 year o acceptable ● Reflex HPV test o preferred	● Repeat co-testing in 3 years	● Colposcopy
LSIL	● Repeat pap test in 1 year	● Colposcopy	● Repeat pap test in 1 year o preferred ● Colposcopy o acceptable	● Colposcopy
ASC-H	● Colposcopy	● Colposcopy	● Colposcopy	● Colposcopy
HSIL	● Colposcopy	● Excisional treatment or colposcopy	● Excisional treatment or colposcopy	● Excisional treatment or colposcopy

Co-testing = Pap and HPV testing

Moises Dominguez

VAGINAL INFECTIONS

VAGINITIS

- Vaginitis is inflammation of the vagina
- It is due to an imbalance of yeast and bacteria that normally live in the vagina

- The most common kinds are:
  - Bacterial vaginosis
  - Candida infection
  - Chlamydia
  - Gonorrhea
  - Trichomonas
  - Viral vaginitis

Bacterial Vaginosis

- THE most common vaginal infection
  - Do not need to treat partners
- Caused by Gardnerella vaginalis – a natural vaginal inhabitant
  - Imbalanced vaginal pH causes an overgrowth which leads to symptoms
- 50% of women are asymptomatic
  - common symptoms: “fishy” odor, dysuria, thin/watery discharge, itching, low pelvic cramping
  - think UTI symptoms without evidence of a UTI
- Common risk factors:
  - smoking, multiple partners, vaginal cleaning products, IUD

Bacterial Vaginosis

- **Treatment (per CDC)**
  - Metronidazole 500 mg orally 2 times/day x7 days
  - Metronidazole gel 0.75% one full applicator (5 g) intravaginally, once a day x5 days
  - Clindamycin cream 2% one full applicator (5 g) intravaginally at bedtime x7 days
- **Alternative Regimens (per CDC)**
  - Clindamycin 300 mg orally 2 times/day x7 days
  - Clindamycin ovules 100 mg intravaginally at bedtime x 3 days
  - Secnidazole 2 g oral granules in a single dose
  - Tinidazole 2 g orally once daily for 2 days
  - Tinidazole 1 g orally once daily for 5 day

- **Prevention**:
  - clean sex toys after every use
  - don't douche
  - limit number of sex partners.
  - use only water & soap to wash your genitals
  - wipe from front to back when using the bathroom

- **Recurrent Infections:** refer for long-term management
  - 6+ diagnosed infection in 1 year
    - prolonged vaginal antibiotics followed by intermittent self treatment
    - chronic intermittent self treatment
    - long-term vaginal pH management
    - vaginal estrogen therapy

Vaginal Candidiasis

- The 2nd most common vaginal infection
  - Do not need to treat partners
- Caused by Candida – a natural vaginal inhabitant
  - Imbalanced vaginal pH causes an overgrowth which leads to symptoms
- Symptoms
  - itchiness of the vagina and vulva – both internal & external itching
  - redness and swelling of the vagina and vulva
  - thick, white "cottage cheese" discharge from the vagina
- Common risk factor
  - Pregnancy, Diabetes, antibiotics, some birth control pills, douches, vaginal sprays, lubricants, spermicides, weakened immune system, wearing a wet bathing suit or workout clothes or underwear that doesn't breathe

Vaginal Candidiasis

Over-the-Counter (per CDC)

- **Clotrimazole 1% cream** 5 g intravaginally daily for 7–14 days
- **Clotrimazole 2% cream** 5 g intravaginally daily for 3 days
- **Miconazole 2% cream** 5 g intravaginally daily for 7 days
- **Miconazole 4% cream** 5 g intravaginally daily for 3 days
- **Miconazole 100 mg vaginal suppository** one suppository daily for 7 days
- **Miconazole 200 mg vaginal suppository** one suppository for 3 days
- **Miconazole 1,200 mg vaginal suppository** one suppository for 1 day
- **Tioconazole 6.5% ointment** 5 g intravaginally in a single application

Prescription Agents (per CDC)

- **Butoconazole 2% cream** (single-dose bioadhesive product) 5 g intravaginally in a single application
- **Terconazole 0.4% cream** 5 g intravaginally daily for 7 days
- **Terconazole 0.8% cream** 5 g intravaginally daily for 3 days
- **Terconazole 80 mg vaginal suppository** one suppository daily for 3 days
- **Fluconazole** 150 mg orally in a single dose

Vaginal Candidiasis

- Special Considerations
  - Recurrent is defined as 3+ symptomatic infection in1 year
    - Refer for long term management
  - **Diabetics:**
    - might not respond as well to short-term therapies and more prolonged (i.e., 7–14 days) treatment is necessary
  - **HIV Infection:** colonization rates among women with HIV infection are higher
    - long-term prophylactic therapy with fluconazole 200 mg weekly has been effective in reducing *C. albicans* colonization and symptomatic recurrent infections
  - **Pregnancy:** occurs frequently during pregnancy
    - Only topical azole therapies, applied for 7 days, are recommended for use among pregnant women. Epidemiologic studies indicate a single 150-mg dose of fluconazole might be associated with spontaneous abortion and congenital anomalies; therefore, it should not be used

Sexually Transmitted Infections

Chlamydia

- The most common STI in women age 18 -35
- 75% of infections in women are asymptomatic
  - 50% in men are asymptomatic
  - symptoms: discharge, bleeding between menses or postictal bleeding, pelvic pain
- If untreated can used PID & infertility
- Annual screening should be offered (18-35yrs)
- Can spread by vaginal/oral/anal intercourse
- Treatment (per CDC)
  - Recommended: Doxycycline 100 mg orally 2 times/day for 7 days
  - Alternative: Azithromycin 1 g orally in a single dose

Gonorrhea

- Women contract it easier than men
- 75% of infections in women are asymptomatic
  - symptoms: discharge, bleeding between menses or postictal bleeding, pelvic pain
- Increased likelihood of contracting HIV
  - If untreated can used PID
- Annual screening should be offered (18-35yrs)
- Can spread by vaginal/oral/anal intercourse
- Treatment (per CDC)
  - Recommended: Ceftriaxone 500 mg IM in a single dose for persons weighing <150 kg
  - Alternative: Gentamicin 240 mg IM in a single dose PLUS Azithromycin 2 g orally in a single dose

Sexually Transmitted Infections

Trichomonas

- Caused by a tiny once cell parasite named *Trichomonas vaginalis*
- It affects women more than men & older women more than younger women
- Diagnosed by urine, PAP & genital fluid NAAT
- 70% of people don't have symptoms
  - might not show up until days or weeks later
  - common sign is a frothy greenish discharge
  - can create significant vaginal/vulvar irritation
- Treatment (per CDC):
  - Recommended: Metronidazole 500 mg 2 times/day for 7 days (2 g orally in a single dose for men)
  - Alternative: Tinidazole 2 g orally in a single dose

HPV

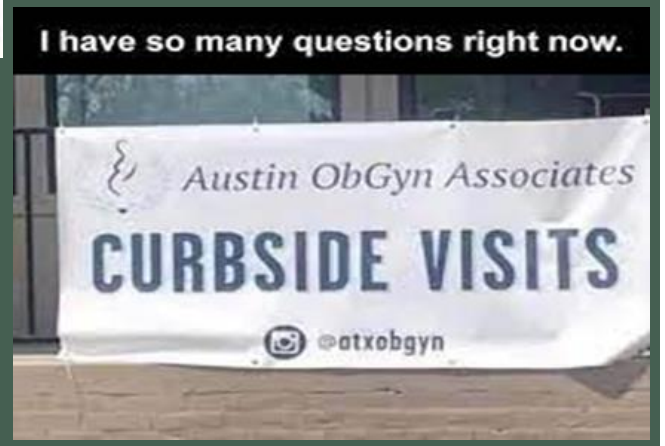
- The MOST COMMON of all the STIs
- Transmitted through skin-to-skin contact
  - Not just sexual transmission
  - causes genital, common, flat and plantar warts
- No treatment – can treat symptomatic warts
- Often asymptomatic
- More than 100 types/strains
  - High-risk strains include 16 and 18
    - they cause about 70% of cervical cancers
  - Low-risk strains include 6 and 11
    - They cause about 90% of genital warts
- Can cause various cancers:
  - cervix, vagina, vulva, head & neck, anus, penile

Questions?


No, no, I'm not really an OB/GYN, but I play one in Congress.
yourecards


When your OBGYN keeps telling you to scoot closer to the edge


OBGYNs: *constantly assessing fetal health throughout the pregnancy*
OBGYNs the moment the baby is born:


I have so many questions right now.
Austin ObGyn Associates
CURBSIDE VISITS
@atxobgyn