Welcome to Ultrasounds, a podcast by OBGYN Delivered. I'm Rachel, a fourth year medical student, and welcome back to our OBGYN Clerkship Survival Guide series where I will be sharing some tips and tricks for various parts of an OBGYN clerkship. Hopefully you've checked out the rest of the series - so far we have covered labor and delivery, vaginal birth, and C sections. Today, we'll be touching on clinic! Part of what makes OBGYN really unique is the mix of environments with L&D, the OR, and clinic! So we will be giving an overview of the most common visits and chief concerns you can expect to see in clinic.

To outline this episode, we are going to cover prenatal visits, HMEs, and a couple of the more common chief concerns including vaginitis, AUB, and pelvic pain.

The first type of visit you can expect to see is prenatal visits! There are 4 key history taking questions for each prenatal visit - any bleeding? Any leaking of fluid? Is the baby moving (expected at about 20 weeks and on)? And any contractions?. Each visit also includes measuring fetal heart tones with a doppler (can usually find at 14 weeks and beyond) as well as measuring the fundal height (pubic bone to top of uterine fundus) from about 20 weeks and beyond. You also often discuss and educate about common symptoms of pregnancy such as nausea, muscles aches/pains, mood concerns and conservative and medical options to manage them. Later in pregnancy, delivery method and timing is discussed.

There are also many screening tests and ultrasounds to complete. I will describe them briefly and you can reference an ACOG guide I will link below - it's made for patients but a very helpful overview:
1st tri - dating ultrasound/confirmation uterine pregnancy, labs (CBC, T&S, UA w/ culture, infectious diseases HIV, rubella Abs immunity, hep B&C, syphilis, chlamydia and gonorrhea), genetic testing if desired, nuchal translucency US
Anatomy scan - 20 weeks
28 weeks - Glucose tolerance test, Rhogam,Tdap
36 week GBS, positioning US

After delivery, there is also a 6 week postpartum visit. Some key things to address here are how healing is going (either c section or vaginal! Perhaps had stitches), if they have any questions/concerns about their labor and delivery experience, any pain, still bleeding?, breastfeeding if they are pursuing that, mood concerns, possible return to sexual activity and plans for contraception.

Another type of visit you are certain to see frequently is health maintenance exams, sometimes called well woman visits or just an annual. If you have done your family medicine or IM rotations, these are similar with a focus on reproductive health. It's helpful to brush up on the general USPSTF guidelines, which is the United States Preventive Services Task Force, for guidelines such as colon cancer screening, lung cancer screening, osteoporosis screening, etc. I will link the USPSTF A&B level recommendations in the show notes. But I want to draw your attention specifically to cervical cancer screening and breast cancer screening.

The guideline for cervical cancer screening reads:
“Every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, or every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).”

Let’s break that down a bit - so it’s important to understand here the cytology vs HPV testing. So when you take samples from the cervix in a pap smear the cells collected can be examined for any signs of dysplasia that clue into potential cancer or precancer. The sample can also be tested for the HPV virus, and then if detected the specific strain. There are certain strains that are at much higher risk for developing into cervical cancer - a little pearl here for you - strains 16 and 18 are the most likely to lead to cancer. Because HPV is so highly related to cervical cancer, evidence has shown that screening for HPV alone is effective, and testing negative for HPV makes someone very low risk to develop cellular changes in the following 5 years, hence why with HPV testing the interval between screening is 5 years with HPV testing. There is some additional context here just for your awareness - these guidelines are still relatively new (with the old guidelines having more frequent screening) and I’ve seen practice patterns that vary. I also commonly saw patients who were uncomfortable waiting several years between pap smears, especially older patients who were accustomed to getting paps yearly at some point. So you may see some patients requesting more frequent screening or providers offering more that. But in summary, patients should between 21 and 29 get paps every 3 years, and patients 30-65 get paps with HPV testing every 5 years. We also have a previous episode diving deeper into this topic!

Okay, mammograms! There’s also some gray area with these guidelines. So the USPSTF guidelines recommend mammograms every 2 years for women aged 40-74 at average risk for breast cancer. However, the National Comprehensive Cancer Network recommends every year. ACOG has basically taken the middle ground with screening every 1-2 years using shared decision making. Personally, I saw providers exclusively recommending yearly mammograms. Yearly breast exams as well as breast self awareness are also included in these guidelines. Historically, women were encouraged to do monthly self breast exams; however, evidence showed this led to unnecessary testing and imaging and the focus has shifted to general awareness about what is normal for your breasts, so you may hear your attendings counseling patients on that concept.

Some other guidelines I would check out are STI screening - there are USPSTF guidelines for HIV, chlamydia, and gonorrhea testing as well. IPV screening is also relevant to this population and supported by USPSTF guidelines.

In addition to addressing preventative care, annual wellness visits include history taking regarding reproductive health - so questions about periods (last one? Length of cycles, heavy bleeding/how often change pad or tampon, pain with periods), sexual history (sexually active, what type of partners, what types of sex (oral, anal, vaginal), hx STIs, contraception, family planning, pain, pleasure), hx abnormal paps, OB hx (how many pregnancies, deliveries term

and preterm, abortions (spontaneous miscarriages). There is quite a bit of nuance here and we do have previous episodes on sexual functioning and contraception for more of a deep dive into those topics. Another thing to note is differences in these visits based on age and menopause status. Questions regarding periods and vaginal bleeding are obviously more relevant to premenopausal women, but it is also very important to know if women who are in menopause have had vaginal bleeding. Women can also experience changes in bleeding patterns in perimenopause that are helpful to dive into. For peri and menopausal women, they may have other related concerns like vaginal dryness, mood changes, insomnia just to name a few so it's important to touch on these topics for women who are no longer having periods.

Last thing I will touch on for HMEs is the physical exam - this consists of a breast exam and pelvic exam, speculum and bimanual. These can be intimidating as a medical student because they are of course more sensitive than the other exams you've done. I think the basics to help with these are very open communication with your patient - asking permission at each step along the way "may I move your gown and begin the exam?", "here's my glove on your thigh" Language is really important here as well, we want to avoid any language that could be interpreted as sexual in nature for example saying exam table instead of bed, knees fall to the side vs spread legs

Apart from HMEs and prenatal care, you will of course see problem visits. I'm just going to touch on a few of the most common concerns you may see.

First, some form of vaginitis. Vaginitis describes a constellation of symptoms like irritation, itching, pain of vagina or vulva as well as abnormal discharge. Some key history questions to ask here would be color and texture of discharge, odor of discharge, recent sexual exposures, antibiotic use, and if this has ever happened before. Some basic diagnostics to parse out the cause of vaginitis are a vaginal culture, wet prep, STI test, and of course a physical exam.

Here are some common causes of vaginitis and a few key details about them:
Candidiasis aka yeast infection - itching, burning irritation with white chunky "cottage cheese" like discharge, can be associated with recent antibiotic use. Can see yeast on a wet prep or vaginal culture. Treated with vaginal or oral antifungal.
Bacterial vaginosis - overgrowth of anaerobic bacteria in vagina, gray watery fishy smelling discharge, can be diagnosed with a wet prep showing clue cells, pH>4,5, or a positive whiff test. Treated with oral or vaginal metronidazole.
Trichomoniasis - protozoa, STI, green/yellow bubbly discharge, a nucleic acid amplification test or NAAT is preferred diagnostic test, treated with oral metronidazole (for your patient and partner!)
Chlamydia or gonorrhea - itching, unusual discharge, burning, burning with urination, often asymptomatic (hence screening!), NAAT (swab or urine!), chlamydia doxycycline, gon ceftriaxone (again your patient and partner!)
Genitourinary syndrome of menopause - lower estrogen causes vulvovaginal atrophy -> irritation, pain, pain with intercourse. Not associated with abnormal discharge. Quite common in postmenopausal patients! Treat vaginal estrogen

Skin conditions - lichens sclerosus, itching, not associated with abnormal discharge whitening of skin on exam, fusing of skin, treated with topical steroids, also more common postmenopausal

Refer to practice bulletin 215 for more details!

Next up, abnormal uterine bleeding! This encompasses a broad range of issues with menses from heavy bleeding, long periods, severe pain with periods to no periods at all. Some key history questions here include date of last period, length of periods, bleeding pattern (can quantify by asking how often they have to change a pad/tampon), time between periods, pain during periods. We have two previous episodes going through possible etiologies of AUB and the go to mnemonic PALM COEIN which stands for polyps, adenomyosis, leiomyomas (aka fibroids), malignancy, coagulopathy, ovulatory dysfunction, endometrial, iatrogenic, not otherwise specified. Depending on the clinical picture, some first steps in workup include physical exam, endometrial biopsy, pelvic US, basic labs like CBC, pap smear. I will also link this related practice bulletin in show notes!

Last one I'll touch on is pelvic pain or lower quadrant pain. A quick differential may include ectopic pregnancy, ovarian cyst/rupture/torsion, PID, endometriosis, miscarriage, fibroids. Of course, there could be many non-gynecologic causes of lower quadrant pain too - UTI, kidney stone, diverticulitis, to name a few. Specific gyn workup may include pelvic exam, UA, pregnancy test, STI screen, pelvic US. There's a great write up from AAFP that you can refer to for more ideas on this!

Whoo that was a long one! Thanks for sticking with me - definitely check out all the great resources in the show notes to help you feel ready to tackle OBGYN clinic! Thanks for listening, and always remember - we put in the labor so you can deliver!

Shownotes:
Prenatal Visits
Routine Prenatal Testing
UltraSounds Routine Prenatal Care

Preventative Care
USPSTF A&B Guidelines
NCCN Breast Cancer Screening
ACOG Breast Cancer Screening
UltraSounds Cervical Cancer Screening
UltraSounds Contraception
UltraSounds Sexual Functioning

Problem Visits
ACOG Bulletin 128 Diagnosing AUB
UltraSounds AUB PALM
UltraSounds AUB COEIN

ACOG Bulletin 215 Vaginitis
UltraSounds STIs
AAFP Lower Quadrant Pain