FP Changes

- Clinical references such as ACOG publications, medication package instructions, etc. have been updated throughout chapter

FP Changes

- Omitted references to the FP Plan First Private Provider Visit and Plan First Contraceptive Order Form
- This change went into effect from Medicaid in November 2009 and was transitioned out of the Health Department through January 2010

Family Planning Service Guidelines

- "Women of childbearing age are eligible to receive services in the Family Planning program. This includes young women who have not yet had menarche, until they have reached menopause (one year post LMP), or received permanent contraception (sterilization)."

FP Deferred Physical: Initial/Annual

- Based on a new initiative in the FP and STD programs to increase Gonorrhea and Chlamydia testing on patients who may not routinely get tested, the following guidance was included

FP Deferred Physical: Initial/Annual

- "In general, lab work is deferred during this visit, however, urine based testing for GC/CT should be made available and offered to any patient seeking services, particularly if she has verbalized unprotected intercourse."

Reminder

- FP Deferred Physical: Initial/Annual
  - There is no "30 day rule" for repeating STD tests in the FP programs

FP GYN Problem/Laboratory/ Counseling Visit

- **"GC/CT urine based testing should be made available and offered to any patient seeking services, particularly if he/she has verbalized unprotected intercourse."**

Clinical Indicators

- **Gonorrhea/Chlamydia Test**
  - **New criteria added: "May offer when not required during routine visits, particularly when patient has verbalized unprotected intercourse"**
- **Pregnancy Test**
  - **Tests may be done per Nurse or NP discretion**

Preconceptional Counseling Guide

- **Added new patient education postcard, "Be Healthy, Be Ready, Be In Control" (ADPH-FHS-563) to listing of materials to review with patients**

Sexual Coercion

- **Included additional information regarding recognizing warning signs of coercion/abuse, and providing sensitive, nonjudgmental counseling**

Common Diagnosis and Contraceptive Issues

- **Changes include**
  - **Added introductory page to this section describing its use and references used in its development (ACOG, WHO, etc.)**

Common Diagnosis and Contraceptive Issues

- **Auto Immune Disorders (Systemic Lupus Erythematosus/Rheumatoid Arthritis)**
  - **NP must consult prior to initiating or continuing any hormonal method**

Common Diagnosis and Contraceptive Issues

- General recommendations for patients with two or more risk factors (diabetes, hypertension, obesity, smoking, or ≥ 35 years of age)
  - Reformatted for better clarity
  - No content changes made

Common Diagnosis and Contraceptive Issues

- Endometriosis
  - Omitted continuous use of vaginal rings
  - Continuous use of Ocs may still be used

Common Diagnosis and Contraceptive Issues

- Thromboembolic disorders
  - Deep Vein Thromosis (DVT)
    - Included Mirena and Paragard as contraceptive options

Depo-Provera/ Medroxyprogesterone Acetate

- Treatment options for heavy or prolonged menses have changed
  - Conjugated estrogen (Premarin) has been omitted as a treatment options

Depo-Provera/ Medroxyprogesterone Acetate

- Added a new option for NP consideration
  - Doxycycline – 100 mg twice daily x 5 days
- Rationale for use is based on the probability that the abnormal bleeding may be associated with endometritis or inflammation of the endometrium

ECPs

- Plan B should be made available to patients to have on hand
  - This does not have to be ordered by the NP
  - It is covered in the protocol

Reminder

- Contraceptive methods are to be issued based on protocol
- Examples of things NOT to do
  - OCs supplied in three month increments for patients who do not have any medical indication
    - This goes against Title X philosophy
    - We do not need to present a barrier to patients

Reminder

- "Requiring patients to receive a dose of Depo-Provera before inserting an Implanon

Implanon

- Treatment options for heavy or prolonged menses or BTB in women using Implanon have changed
  - Conjugated estrogen (Premarin) has been omitted as a treatment option
  - Added a new option for NP consideration
    - Doxycycline - 100 mg twice daily x 5 days

Implanon

- Post insertion counseling
  - Included reference regarding NP entry into a log of all Implanon insertions and removals
- Removal
  - Included reference to "Implanon/IUD Removal Consent Form" available in English and Spanish on ADPH Document Library

Mirena IUD

- Contraindications - updated information from package insert dated 10/09
- The following conditions were omitted from the listing
  - Current deep vein thrombosis or pulmonary embolism
  - Women or her partner has multiple sex partners

Mirena IUD

- Genital Actinomycosis
- History of ectopic pregnancy or condition that would predispose to ectopic pregnancy

IUD

- Preinsertion
  - Updated patient information hotline numbers
  - Patient complaining of significant bleeding while using IUD
    - Conjugated estrogen (Premarin) has been omitted as a treatment option

IUD

- Added a new option for NP consideration
  - Doxycycline - 100 mg twice daily x 5 days

PHALCON Changes

- PHALCON/Encounter Form Changes
  - Pregnant - added as female contraceptive
  - Omitted the Plan First Private Provider Visit
  - Two fields added to the Patient Screen to identify patients who will not declare their race and ethnicity

Abnormal Findings

- Breast abnormalities - breast mass
  - Included guidelines for referral of adolescent patients (20 years of age and younger) with a breast mass
  - Provide referral to a surgeon

Abnormal Findings

- The HD <u>will not</u> order any additional diagnostic imaging tests (mammogram or ultrasound)
  - This will be determined by surgeon
- Patients who are age 21-29 are to receive a breast ultrasound
- Patients 30 and older are to receive a diagnostic mammorgram

Pap Changes Coming Soon

- ACOG issued revised guidelines for cervical cancer screenings as follows
  1. Screening Paps should begin at age 21 (regardless of history). Screening before age 21 should be avoided because women less than 21 year old are at very low risk of cancer. Screening these women may lead to unnecessary and harmful evaluation and treatment.

Pap Changes Coming Soon

2. **21-29 years of age - every two years. Evidence shows that screening women every year has little benefit over screening every other year.**

Pap Changes Coming Soon

3. **30 years and older - two options**

- **Patients with three consecutive negative screening tests who have no history of CIN 2 or CIN 3, are not HIV infected, are not immunocompromised, and were not exposed to DES in utero may extend interval to every three years**

Pap Changes Coming Soon

- **Co-testing using the combination of cytology plus HPV testing. If both results are negative, screen every three years.**

4. **Women between 65-70 years of age who have three or more negative Pap tests in a row and no abnormal tests in the past 10 years should be discontinued**

Pap Changes Coming Soon

5. **Women who have had a total hysterectomy for benign indications and have no prior history of high-grade CIN, routine cytology testing should be discontinued**

Pap Changes Coming Soon

6. **Women treated in the past for CIN 2, CIN 3, or cancer remain at risk for persistent or recurrent disease for 20 years after treatment and after initial post treatment surveillance, and should continue to have annual screening for at least 20 years**

Pap Changes Coming Soon

7. **Women who have had a hysterectomy with removal of cervix and have a history of CIN 2 or CIN 3, or cancer - or in whom a negative history cannot be documented - should continue to be screened even after their period of post treatment surveillance**

Protocol in the Works - Preview

- Patients 20 and younger
  - Patients in a repeat pap follow-up scheme for ASCUS or LSIL will not be repeated or referred for management until age 21
  - A standing order will be available on the Document Library to address this as we transition

Protocol in the Works - Preview

- During this transition - this does not include the following results which will still require a colposcopy referral
  - ASC-H
  - ASCUS, cannot exclude a more severe lesion
  - LSIL, cannot exclude a more severe lesion
  - HSIL or worse

UAB Colposcopy Screening Guidelines

- Have been updated based on new ACOG guidelines
- Primary change is related to the adolescent patient
  - Referral will be limited for this age group based on new standing order

Worldwide…

- Cervical cancer is the second most common malignancy in women
- > 200,000 women die yearly

In the U.S.…

- 11,000 new cases of invasive cervical cancer are estimated for 2009 and 4,000 deaths in 2009

ASCR

- Estimates in 2008
  - 170 new cases of cervical cancer will occur in Alabama

Cervical Cancer

- Incidence rate in AL is 9.8
  - Higher than U.S. of 8.5
- Mortality rate in AL 3.1
  - Slightly higher than national rate of 2.4

Cervical Cancer

- Cervical cancer incidence has declined by 1/3 in the U.S. within the last 20 years
- The elderly, the economically disadvantaged and those who are not regularly screened are disproportionately represented among women who develop and die from this disease

ACS Estimates

- Between 60% & 80% of American women with newly diagnosed invasive cervical cancer have not had a Pap Smear in the past 5 years

Risk Factors for Cervical Cancer

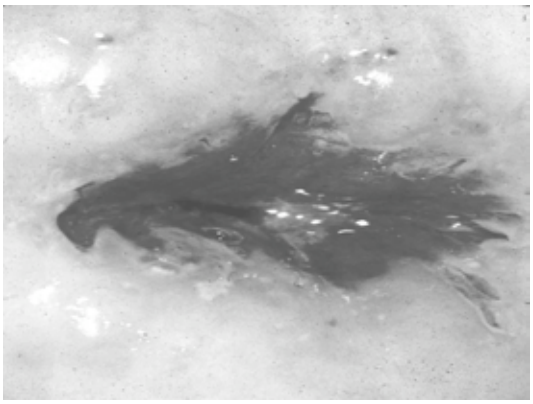
- Young age at first coitus
- Multiple sex partners
- High parity
- Smoking
- Immunosuppression (e.g. HIV)
- Long term use of oral contraceptives
- H/O sexually transmitted diseases
- HPV infection

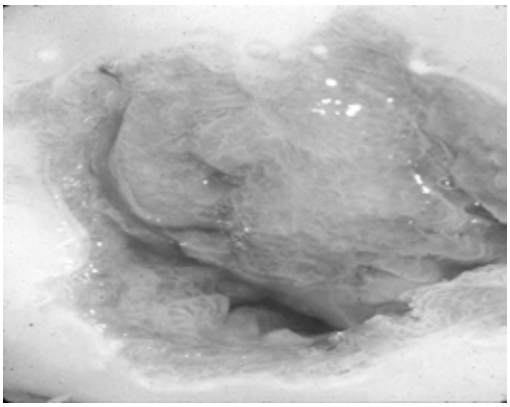
Epidemiologic Studies

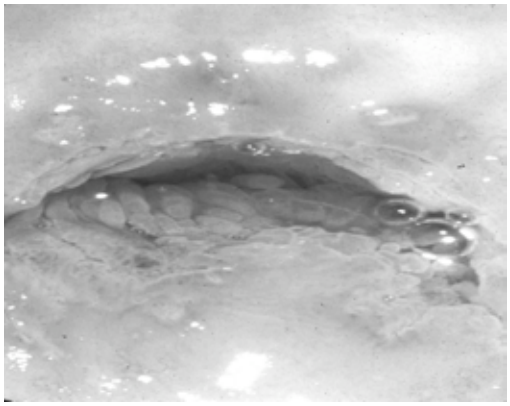
- HPV infection to be the most important risk factor for the development of pre-cancerous lesions (LGSIL, etc.) and invasive squamous carcinomas
- Prevalence of HPV DNA in more than 90% of pre-invasive & invasive lesions

HPV

- > 100 HPV types identified
- > 40 types infect the genital tract
- Genital HPV primarily targets squamous epithelium and cells within the squamocolumnar junction
- Majority of cervical cancer is squamous cell







Low Risk HPV Types

- Caused by HPV types 6 and 11
- Cause genital warts (condyloma acuminata)
- Rarely develop into cancer
- Cause low grade changes in the cells of the cervix, most resolve spontaneously

High Risk HPV Types

- Linked to anogenital cancer in men and women
- Common high risk types include: 16, 18, 31, 35, 39, 45, 51, 52, 58
- ~ 70% of cervical cancers in U.S. caused by types 16 or 18

High Risk HPV Types

- Can cause low grade/high grade changes
  - Precancerous and cancerous changes in the cells of the cervix

Precancerous Cervical Conditions

- Detected when a Pap Smear is done
- Bethesda System used to report Pap Smear results
  - 3 main categories
    - Negative for intraepithelial lesion or malignancy

Precancerous Cervical Conditions

- Epithelial cell abnormalities
  - ASCUS, LGSIL, ASC-H, HGSIL
- Cancer

HPV DNA Test

- Tests specifically for high risk HPV types 16 and 18
- Used in women with ASCUS pap result
- Used with Pap Smear for screening in women 30 and older
- Almost always positive with LGSIL and HGSIL

Genital HPV Infection/Transmission

- Most common STI in the U.S.
- 6.2 million Americans infected each year
- > 50% of all sexually active men and women become infected at some time in their lives

HPV Infection

- Prevalence is highest among sexually active women in their 20's
- Stabilizes after age 45
- May not always cause warts
- May have HPV for years without symptoms

HPV Infection

- Most genital infections do not cause cervical cancer
- Most who test HPV+, test negative within 6 - 12 months
- Often leads to cytologic abnormalities (LGSIL, ASCUS) while actively shedding DNA
- Majority clear spontaneously in 1 to 2 years

HPV Infection

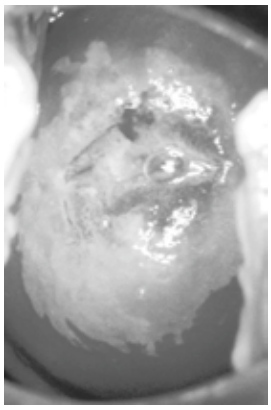
- Unclear how many HPV infected women who later become HPV negative have cleared the virus
- Latent infection – harbor virus at low levels, undetectable by standard testing
- Reactivation of latent virus

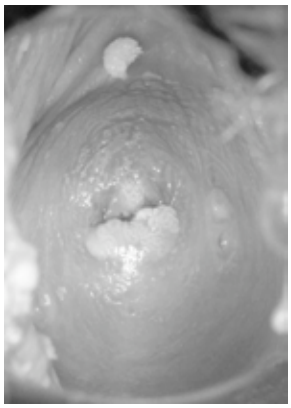
HPV Infection

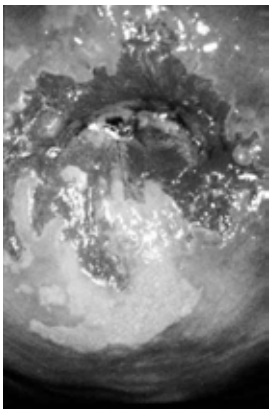
- Cannot distinguish between reactivation and newly acquired infection

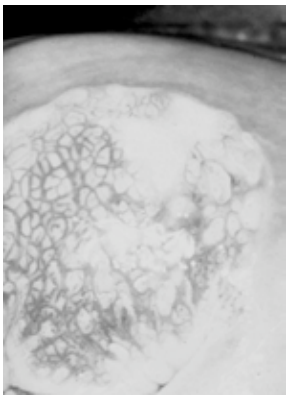
Treatment of HPV Infection

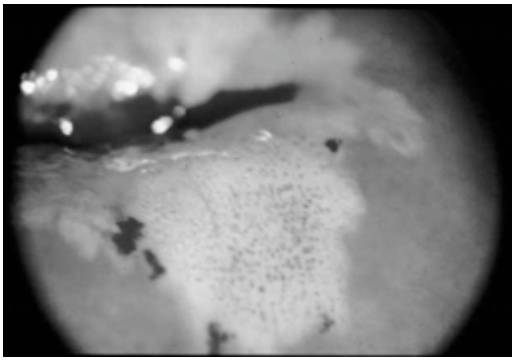
- No cure to eliminate HPV, treat epithelial cell abnormalities
- Colposcopy and biopsies
- Biopsy results are reported as CIN instead of SIL
- Cryosurgery, LEEP, cone biopsy
- Topical treatments for external genital warts





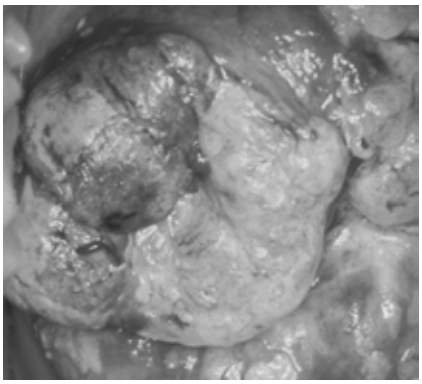


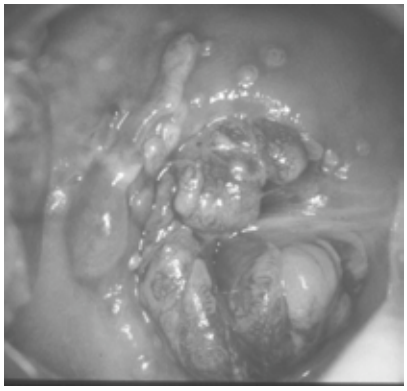


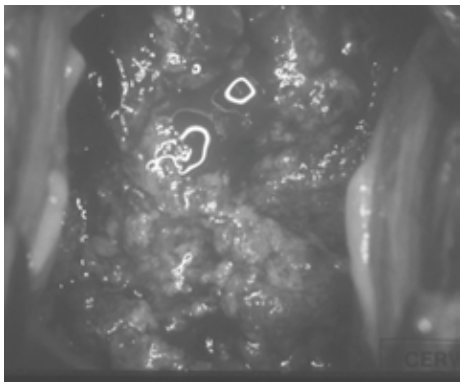


Treatment of HPV Infection

- **Invasive cervical cancer may be detected when performing colposcopy**
- **Referral to Gyn oncologist for staging, treatment and follow-up**







Prevention of HPV Infection

- Avoid being exposed to HPV
  - Avoid risky behavior
  - Multiple partners
  - Delay sexual debut
- Use condoms – provide some protection

Prevention of HPV Infection

- Don't smoke
- Get vaccinated
- Get screened
  - Treat precancerous conditions

Cervical Cancer Screening

- Should begin at age 21
- Cervical cytology screening every 2 years for women between the ages of 21 and 29
- Women aged 30 and older who have had 3 consecutive negative cervical cytology smears, may be screened every 3 years

Women Who Are

- Infected with HIV
- Immunosuppressed
- Were exposed to DES in utero
- Women previously treated for CIN2, CIN3, or cancer

Screening

- A woman's past screening history must be taken into consideration before an upper age limit is recommended for discontinuation of screening
- ACS recommends age 70

Screening

- USPSTF recommends age 65 as the upper limit of screening
- Women who have had total hysterectomy for benign indications and no prior h/o CIN, should discontinue routine cytology testing
  - Ref: ACOG Practice Bulletin #109, 12/09

American College of OB/GYN

- Reasonable to discontinue screening at 65 or 70 years of age in women who have 3 or more negative cytology results in a row and no abnormal test results in the past 10 years
  - Ref: ACOG Practice Bulletin #109, 12/09

Take Home Points

- HPV infections are commonly acquired by young women shortly after the initiation of vaginal intercourse, but, in most cases, they are cleared by the immune system within 1 - 2 years without producing pre-cancerous or cancerous changes

Take Home Points

- Risk of neoplastic transformation increases in those women with persistent infections

Take Home Points

- Get screened!
  - Screening offers the best chance for early detection of cervical cancer & successful treatment
- Getting one of the HPV vaccines before being exposed to HPV will prevent some HPV

Take Home Points

- Modify behavior
  - Consistent use of condoms reduces, but does not prevent transmission

Pap Case Study #1

- A 20 year old nulligravida presents for first pelvic examination. She describes one sexual encounter and heard that she should be tested for HPV.
  - What do you offer her?

Pap Case Study #1

- Response
  - The prevalence of HPV is highest among women ages 21-24
  - Although women younger than 21 also have a high prevalence of HPV infection, these women are considered to be low risk, specifically since this infection is likely to be shorter and to resolve independently

Pap Case Study #1

- HPV test alone not recommended
- Pap smear not to be performed until patient turns 21 years old
- Provide pelvic exam, with speculum observed assessment of cervix, GC/CT, VDRL, and HIV testing

Pap Case Study #2

- A 35 year old woman presents for a Pap test. Although she had a history of cervical intraepithelial neoplasia (CIN 2 per biopsy with LEEP treatment) in her 20s, her last 2 Pap tests and HPV tests were negative.
  - What do you offer her?

Pap Case Study #2

- Response
  - Based on this patient's prior history of CIN 2 with LEEP, she is deemed high risk and is to be offered a Pap smear annually
    - If results indicate ASCUS, a reflex HPV test should be performed

Pap Case Study #3

- 20 year old patient in for annual exam and contraception. Her Pap smear history includes ASCUS, followed by LSIL over the past two years. Her Pap results return with ASCUS.
  - What follow-up management do we do?

Pap Case Study #3

- Response
  - Based on current ACOG guidelines, patients in this age group will not be screened with a Pap smear until age 21
    - In this case, despite the ASCUS/LSIL/ASCUS history, ADPH will stop Pap screenings until the patient turns 21

Pap Case Study #4

- **19 year old patient seen last month for Annual exam. Pap results indicate *ASCUS*, *cannot exclude a more severe lesion***
  - **Based on the new guidelines, what management do we follow?**

Pap Case Study #4

- **Response**
  - **A patient of any age with the results *ASCUS*, *cannot exclude a more severe lesion,* are to be referred for colposcopy**
  - **Make sure to read the Pap report in it's entirety**
    - **Other codes would include *ASC-H, LSIL, cannot exclude a more severe lesion, HSIL, or worse***

Pap Case Study #5

- **A 60 year old woman presents for her annual exam. She reports that at age 48 she had a hysterectomy for cervical cancer. She has been without evidence of disease since then and wonders if she needs annual screening and HPV testing?**
  - **How do you counsel her?**

Pap Case Study #5

- **Response**
  - **This patient is considered high risk based on the history of cervical cancer, despite the hysterectomy. Annual smears of the vaginal cuff should be performed**
  - **In all cases, the nurse and NP should document pertinent history on the Pap smear requisition**