OBG MANAGEMENT

Mark S. DeFrancesco, MD, MBA
Chief Medical Officer
Women's Health Connecticut
Avon, Conn

mark.defrancesco@womenshealthusa.com

How to keep the annual visit *annual*

Pap test or no Pap test, every woman needs a yearly exam, for reasons vital to her health—and to ObGyn practice.

An ObGyn in the audience steps up to the microphone after my lecture on cervical disease screening.

> "Ever since the new recommendation that some women might need a Pap test only every 3 years, I've been concerned that a lot of my patients will just stop coming in. They won't ask my opinion; they'll read about it in one of their women's magazines . . . and then I'll notice that a lot of my regular patients who came in once a year just won't be coming in."

Are we committing economic suicide and alienating our patients if we implement screening guidelines that do not insist upon a Pap test for every woman, every year? It's a fear that many ObGyns share.

It doesn't have to be that way. In our practice, we've discovered that following overall good health screening guidelines is an opportunity to *build* the practice, *strengthen* relationships with our patients, and improve women's health.

True, the American College of Obstetricians and Gynecologists' recommendations do state that an interval of 3 years between Pap tests is appropriate in specific cases.

Nowhere is it suggested, however, that we dispense with the annual visit.

To the contrary, the US Preventive Services Task Force (USPSTF) advises every American woman to take a copy of its "Checklist for Your Next Checkup" to her doctor, and ask which of the following screenings and strategies are right for her, and how often she should have them: mammogram, Pap test, cholesterol check, blood pressure, colorectal cancer tests, diabetes tests, depression, osteoporosis tests, chlamydia tests and tests for sexually transmitted diseases, hormones, breast cancer drugs, aspirin, and immunizations.

The good news is that new cervical screening technology means we can recognize or rule out HPV infection with unprecedented accuracy, more swiftly identify and treat precancerous lesions, and better prevent cervical cancer. Popular misconceptions may threaten to make some women skip their annual exams, but we can counsel every patient—and demonstrate by the care we provide—why it is not recommended that women skip their annual visit.

Use the annual visit for comprehensive care

Many of our patients seldom if ever see another physician (despite writing their PCP's name on their intake sheet in our office). Consequently, many of them never get comprehensive health screening unless we provide it. Besides being "the right thing to do," screening for and identifying other problems at the annual visit allows us to

CONTINUED

IN THIS ARTICLE

KEY SOURCES

For patients

Checklist for Your Next Checkup
www.ahrq.gov.ppip/healthywom.htm

For ObGyns

Human Papillomavirus. ACOG Practice Bulletin
Obstet Gynecol. 2005;105:905–918.

USPSTF Guidelines
www.ahrq.gov/clinic

HPV SCREENING

Negative concurrent cervical cytology and HPV DNA testing:

- Risk of unidentified CIN 2/3 or cancer is about 1 in 1,000
- Negative predictive value for CIN 2/3 is 99% to 100%

Triage using reflex HPV DNA testing after liquid-based ASC-US cytology:

- Eliminates the need for a repeat office visit
- Is a more sensitive triage tool than repeat cytology
- Refers fewer women to colposcopy

Cytology-negative/high-risk HPV DNA-positive/ age 30 or older:

- Does not call for immediate colposcopy. Instead, repeat both tests in 6 to12 months, and refer to colposcopy only if high-risk HPV persists or if cytology is LSIL or greater.

High-risk HPV and ASC-US or LSIL cytology, but not CIN 2/3 at initial colposcopy:

- Risk of CIN 2/3 within 2 years is about 10%

Women 30 years and older who have negative combined cytology and HPV DNA results should be rescreened no more than every 3 years

Source: ACOG Practice Bulletin No. 61

schedule follow-up visits to evaluate or monitor treatment of those problems, if we do not otherwise refer the patient. Such follow-up visits, if they are in our scope of practice, are good for the practice and for the patient.

Patient satisfaction will increase due to the opportunity to "one-stop shop," and I've found that patients truly appreciate our concern for their overall health.

Telling patients that the Pap test is not needed this year (because they had a negative Pap and negative HPV test last year) has not been a problem. They know that when they come in for their annual visit, it is not just about the Pap test. They are coming in for "well woman care."

It's not as difficult as it looks

Screening can mean asking just a few questions, and very little extra work. For example, we weigh and measure patients anyway, so it is a simple matter to record the body mass index (the medical assistant can calculate it with a simple program made available by the USPSTF). Refer patients for colonoscopy when guidelines call for it or send the patient home with test cards. The depression screen can be as simple as 2 basic questions. The bladder health screen can be 3 or 4 more questions. You can order lipids and other labs.

Not enough time?

Problems identified during the exam can sometimes be dealt with immediately. Otherwise, schedule a follow-up visit; a coding modifier may be appropriate if done at the time of the annual visit.

Benefits to practice

If the Pap interval increases for a woman, she is more likely to see the benefit of an annual visit if she understands that you are providing comprehensive care. You as a clinician will be even more valuable to insurers if you provide more comprehensive care and this may help you drive better fee schedules. And for the patients who haven't been motivated to get an exam every year, even under the perception that an annual Pap was a must, perhaps annual comprehensive health status monitoring will give them a reason to make an appointment.

Obviously we don't want to bypass the rest of the medical system either, and we should refer as appropriate.

How we added USPSTF screening in our practice

The following pages discuss how we implement USPSTF guidelines, in addition to the ACOG guidelines for cervical cancer screening.

CHLAMYDIA SCREENING

What to tell patients

Physicians often assume that we won't find chlamydia in our patients, especially among people who are monogamous, in their mid-20s, or married for several years, so why test? But many times we're also concerned that the patient may be embarrassed or feel we are judging them if we suggest an STD test. An easy solution is to talk in terms of guidelines. Simply say that chlamydia infection is a serious, common disease that can be longstanding but silent, and that the test is recommended as routine for everybody under 25.

I probably find 1 case a month, and I have a middle- to upper-middle class patient population. When you look for it more, you find it more.

In states with chlamydia programs, infection among women has been reduced by as much as 67%. As a nation, we are screening only about 25% to 35% of patients who should undergo chlamydia screening. All sexually active women 25 and younger and all women who may otherwise be at risk—whether or not they are pregnant—should be tested.

Young women are the most important group to screen: 1 in 10 teenage girls tested for chlamydia is infected; 15- to 19-year-old girls account for almost half of all reported cases among females; 20- to 24-year-old women account for another 33%.

Women with new or multiple partners, who live where chlamydia is common, and

FAST TRACK

Insist on colonoscopy at 50
"I've had at least 3 asymptomatic women just past age 50 who had early colon cancer found because I kept bugging them"

Ask about domestic abuse
"A patient later told me,' You saved my life'—the question alone had spurred her to take action to protect her safety"

who have had an STD are among important targets for screening women over 25.

BREAST SELF-EXAMINATION

I recommend that all patients do self-examination. The Task Force concludes there is insufficient evidence to recommend for or against teaching or performing routine self-examination. Still, many women are the first to discover breast cancer.

LIPID SCREENING

I finally got away from fasting blood work because many patients just never go, whereas popping into the lab on the way out of the office and having their blood drawn is more convenient. If the numbers come back poorly then we can assess the next step.

There is virtually no age cutoff—young or old. All women aged 45 *and older* should be screened routinely for lipid disorders—a change from the previous limit of 65. Younger women should be screened if they have diabetes, high blood pressure, or family history of heart disease or high cholesterol, or use tobacco.

COLORECTAL CANCER

I've had at least 3 patients in the last 5 years who had early colon cancer discovered because I insisted they go for colonoscopy. They were just over 50 with no symptoms whatsoever, and I kept bugging them to go. It really made me a believer that colonoscopy is the right thing to be doing.

Colon cancer is the second leading cause of death in the United States, and 80% of cases are in "normal-risk" patients; only 20% occur in "high-risk" patients. A person who dies from colorectal cancer loses an average of 13 years of life. Screening is "strongly" recommended, and should start at age 50.

DIABETES

Although widespread routine screening was not endorsed by the current or the previous USPSTF, the current recommendation is that patients with hypertension or hyperlipidemia be screened, as they are more likely to have diabetes and be in greater need of treatment, as it is a serious comorbidity.

OBESITY

The most effective interventions combine nutrition education and diet and exercise counseling with behavioral strategies. Screen for and treat or refer obese (30 or higher body mass index) patients for intensive counseling and behavioral interventions; consider pharmacological treatment only as part of intensive interventions.

OSTEOPOROSIS

Low weight, no current use of estrogen, and age are incorporated into the 3-item Osteoporosis Risk Assessment Instrument (ORAI), which helps identify women younger than 65 who should be screened (www.osteoed.org/faq/screening/orai.html).

Bisphosphonates, such as alendronate and risedronate; selective estrogen-receptor modulators (SERMs), such as raloxifene; calcitonin; and estrogen can improve bone density and reduce risk for fractures.

DEPRESSION

All patients should be screened for depression—if there are systems in place to assure accurate diagnosis, effective treatment, and careful follow-up.

Asking these 2 questions may be as effective as using longer screening instruments:

1. Over the past 2 weeks, have you ever felt down, depressed, or hopeless? (I may add, ". . . any more than is usual these days?")
2. Over the past 2 weeks, have you felt little interest or pleasure in doing things?

Patient outcomes improve significantly when depression recognition and management are integrated into usual care in primary care practices.

THYROID DISEASE

We do not test routinely, but if there are menstrual irregularities or amenorrhea, or if a patient is gaining weight and feeling tired, it may be enough to trigger a check.

Consider testing if there are symptoms of hypothyroidism (unusual tiredness,

INTEGRATING EVIDENCE AND EXPERIENCE

De-stigmatizing HPV testing in 90 seconds or less

Michael D. Randell, MD
Department of Obstetrics and Gynecology
Northside Hospital, Atlanta
www.obgynatlanta.com

The message is clearer than ever: screening for cervical disease involves being prepared to offer HPV DNA testing.

- This year, for the first time, the federal government put HPV on its annual list of **known human carcinogens**.[1]
- Screening strategies in the April 2005 **American College of Obstetricians and Gynecologists' Practice Bulletin** include: 1) triage of all women with ASC-US cytology using *reflex* HPV DNA testing for high-risk HPV types; 2) in women over 30, *primary* testing using a combination of cervical cytology and HPV DNA screening.[2]

A sensitive issue. Unlike the "neutral" terms (ie, dysplasia or CIN) we used to explain the Pap smear for cervical disease, discussing HPV testing requires using the phrase "sexually transmitted infection." Public awareness of HPV is just beginning.

Few women understand why their ObGyn would advise a test for a sexually transmitted infection "out of the blue"—not realizing that the Pap test has always been a test for the manifestation of HPV infection. We want to avert undue anxiety or offense in our patients, yet provide up-to-date care.

A careful explanation is called for.

Simple but sensitive

Many patients probably are uninformed or misinformed. The news media is no longer the universal "second opinion" on medicine—we are. Media messages reach patients first, and information on HPV is not always accurate.[3]

When a patient comes in for an office visit, it may be her best opportunity—and ours—to discuss the facts.

The ACOG Practice Bulletin includes a detailed, comprehensive discussion on what to counsel patients.

I've developed a way to cover just the basics. I believe that this proactive approach strengthens patient relationships and improves compliance with follow-ups.

The time-tested "5 Ws" formula is failsafe—you can't easily leave out any critical information when offering HPV DNA testing.

WHO "Most women are positive for HPV at some time, and most clear their infection. It is easily transmitted; condoms are not complete protection."

- This points out how common HPV infection is.

WHAT "HPV is the cause of cervical cancer. Testing lets a woman know whether she is at risk for having or developing cervical cancer or a high-grade precursor lesion over the next 3 years."

- This explains that HPV is linked to high-grade lesions and cervical cancer.

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weight gain, feeling cold, constipation, changes in hair or skin) or hyperthyroidism (rapid heartbeat, feeling hot, anxiety, muscle weakness, or trouble sleeping).

BLADDER HEALTH

I've learned from my patients how to conduct a good review of systems, when I'm taking a patient in. If you ask, "Are you having any problem with your bladder?" they all say "No." If you ask, "Do you have any leakage when you cough or sneeze?" they all say "Yes!" So, asking the right questions helps us to at least find who needs further screening and evaluation—and a great many women can be helped if we find the problem in the first place.

Ask specific questions in everyday, nontechnical language.

Even though incontinence can be improved in 8 out of 10 cases, fewer than half of those with bladder problems tell their doctor, and hence go untreated.

INTEGRATING EVIDENCE AND EXPERIENCE

CONTINUED FROM PAGE 27

WHEN "HPV DNA testing is appropriate in women aged 30 or older, in addition to the Pap."

- This statement explains the timing of when to begin primary HPV DNA testing.

WHERE "If your test result is positive, you should not blame your partner, because there is no way to tell where or when you were exposed to the virus. Exposure could have been many years ago."

- This point should be explained in advance of results. Monogamous patients want to know where they got the infection.

WHY "If both the Pap and HPV tests are negative, you'll have peace of mind knowing that you do not have a high-grade cervical lesion or cervical cancer."

- This statement refers to the 99% to 100% negative predictive value for CIN 2 and 3, using concurrent cervical cytology and HPV DNA testing.[2]
- In addition, because HPV DNA testing is more sensitive than cervical cytology for detecting CIN 2 and 3, women with negative concurrent test results can be reassured that their risk of unidentified CIN 2 and 3 or cervical cancer is approximately 1 in 1,000.[2]

If the HPV test is positive, further counseling can involve a similar, straightforward approach, and patients can be managed according to published guidelines.

Skip "low-risk" patients?

Is it reasonable to presume that some patients are not at risk for HPV infection? (If we truly believe that some patients have no risk, why even do a Pap?) Any woman who has ever had sexual intercourse is at some risk, given the natural epidemiology of HPV.

Whereas Pap test results involve subjectivity, HPV test results are objective. If there are no cytological findings in the presence of a positive HPV test, then both tests should be repeated in 6 to 12 months. Women with persistent infections should undergo colposcopy regardless of Pap test results.

Many sexually active women will have an HPV infection at some time in their lives, we can assume. Essentially, testing at age 30 or older tries to ascertain whether the infection has cleared. Women over 30 are the target population for cervical cytology screening with HPV DNA testing.[2] In women younger than 30, HPV is very prevalent, and cervical cancer prevalence is relatively low. But after 30, HPV prevalence is low, and cervical cancer increases. Thus, primary testing is more practical for the older group.

1. National Toxicology Program, Department of Health and Human Services. 11th Report on Carcinogens. Fact Sheet. January 31, 2005. Available at: http://ntp.niehs.nih.gov. Accessed August 15, 2005.
2. American College of Obstetricians and Gynecologists. Human papillomavirus. Practice Bulletin No. 61. April 2005.
3. Anhang R, Stryker JE, Wright TC Jr, Goldie SJ. News media coverage of human papillomavirus. Cancer. 2004;100:308–314.

The author is on the speakers bureaus for 3M Pharmaceuticals, Cytyc Corp, Digene Corp, and Quest Diagnostics.

ASPIRIN

Aspirin is likely to benefit women who are at increased risk for heart disease. We should counsel these patients on both the potential benefits and harms of aspirin therapy.

DOMESTIC VIOLENCE

Ask about domestic violence. We never know the downstream effects of what we do and how we do it.

A few weeks ago, as a patient was leaving my office after we had been discussing other things, she said to me, "I want you to know that last year, when you asked me if everything was okay at home and whether there was any abuse going on, I said no. But when I left your office I went straight to the police station and reported my husband and got an injunction, and we're divorced now.

"You saved my life." ■

DISCLOSURE

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