OBG MANAGEMENT

It's time to re-tool the annual exam: Here's how

Capitalize on patients' habit of visiting your office once a year to implement appropriate services

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Recent advances in the understanding and detection of cervical cancer have resulted in a recommendation to increase the screening interval with a Pap smear from annually to every 2 or 3 years for low-risk patients. We know that cervical cancer requires the persistence of high-risk human papillomavirus (HPV) types to develop, and this knowledge has provided high-level evidence that annual cervical cancer screening is not beneficial for most women.

Where does this shift in the surveillance strategy for cervical cancer leave us? Implementing new screening intervals gives us a wonderful opportunity to reevaluate the annual exam, and to educate ourselves and patients about interventions that make an impact on health.

Eliminate the annual exam?

Do we still need routine encounters with our patients? In this article, I address 2 topics that can help answer the question: I review the evidence that supports annual "well-woman" visits and outline the interventions that have proven benefit.

Time to retire a time-honored tradition

The utility of an annual health visit—ie, a comprehensive head-to-toe physical exam coupled with a battery of tests for early identification of disease and intervention—came into question with the rise of evidence-based medicine in the mid-1970s and, eventually, became unsupportable. In 1979, the Canadian Task Force on the Periodic Health Examination concluded that the value of only a few preventive interventions was supported by data. In 1989, Oboler and colleagues concluded that "comprehensive annual exams in asymptomatic adults have little screening value…"[1]

The American College of Physicians, American Medical Association, US Preventive Services Task Force (USPSTF), and US Public Health Service all concur: The routine, annual, comprehensive physical exam is unnecessary. Instead, physicians should institute a selective approach to identifying and preventing health problems in all patients—one based on gender, age, health history, and risk factors.

Some interventions have helped

The incidence of, and mortality from, cervical cancer dropped strikingly in the United States with the advent of annual screening with the Pap smear. Mammography has recently been proved to increase the early detection rate of breast cancer and to reduce the rate of death from breast cancer. The challenge we face, therefore, is to determine which screening tests and interventions are valuable and will translate into

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TABLE 1

Remember to provide lifestyle counseling!

Don't smoke
Drink alcohol in moderation
Eat healthy—ie, high-fiber, low-fat foods, including fruits and vegetables
Exercise often—ie, aerobic, weight-bearing, and balance activities
Maintain healthy weight*
Use a condom during sexual intercourse
Use a contraceptive

*Be prepared to provide strategies for effective, sustainable weight loss to your patients

improved health outcomes. The USPSTF has set out broad recommendations on 10 areas of screening for women:

- monitor blood pressure
- screen for cervical and colorectal cancers, depression, diabetes, and osteoporosis
- test for chlamydial infection
- measure the cholesterol level
- perform mammography.

New tool helps you develop an exam

Available for you is an excellent online resource developed by the Agency for Healthcare Research and Quality (AHRQ) for adopting the USPSTF screening recommendations. AHRQ has created the "electronic preventive services select" (or ePSS) Web site (http://epss.ahrq.gov), which is searchable by patient sex, age, and behavioral risk factors. The evidence for various preventive services is graded, guiding you on both interventions that are strongly recommended and those that should not be offered routinely because they lack data to support utility.

Make the transition with a systematic approach

We can capitalize on the habit that patients have established and have them come in annually for appropriate, evidence-based services. How do we make the change from the typical ObGyn visit—one that includes a breast and pelvic examination, cervical cancer screening, and mammography—to an evidence-based, annual well-woman visit that can be rapidly implemented and easily documented, using a paper or an electronic medical record?

I recommend creating templates for the annual well-woman visit that are age-specific and include check boxes for the age-appropriate history, physical exam, testing, and counseling that you'll provide. You can create a distinct form for each of the various age and risk groups or, more simply, devise a single form that includes all guidelines for screening, from which you choose the appropriate areas based, again, on age and risk status.

Build a screening form

What should you include on the template that you create? Here are possible items, based on what I use in my practice:

History. Document the patient's age, allergies, medications, contraceptive method, and risk factors (eg, smoking, a history of infection with high-risk HPV types, and a significant family history of colon, breast, and ovarian cancer and of heart disease and diabetes). Develop a problem list of concerns that the patient, and you, have. Note: I ask the patient to complete a checklist review of systems at every annual visit; doing so helps identify specific health concerns she may want to discuss.

Physical exam. Measure height, weight, body mass index, and blood pressure. Check off items included in the examination of breast, abdominal, and pelvic structures, and elaborate on abnormal findings in a space provided. Include an area on the form for noting "other" concerns, such as findings of skin, musculoskeletal, upper respiratory, and cardiac assessments—any of which is performed as indicated.

Lab testing. Document routine testing with 1) a check box to indicate which tests have been ordered and 2) a line on which to note the tests that were identified as appropriate but were not performed or

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Create templates for the annual well-woman visit that are age-specific and that include check boxes for the history, physical, testing, and counseling

were deemed inappropriate—and why. Such documentation is helpful when coding pay-for-performance measures.

Counseling. Develop a list that includes smoking cessation, weight loss, exercise, contraception, and prevention of osteoporosis and sexually transmitted infection. The list helps you recall, and discuss, essential areas (**TABLE 1**, page 66).

The goal in developing and using a template? It provides a single, easy-to-use form that is flexible and applicable to all women, and that encourages consistent adherence to guidelines for screening and prevention.

TABLE 2

The pillars of an annual primary screening program

ESSENTIAL	
• Sexually transmitted infection (*Chlamydia trachomatis*) and cervical cancer (HPV)	• Diabetes
• Breast health	• Colorectal cancer
• Cardiovascular health	• Osteoporosis
	• Depression
OPTIONAL	
• Bladder health (incontinence)	• Domestic violence
• Thyroid disease	

With a format in place, screen in 7 areas

What do guidelines recommend that we embrace as interventions to make a difference in patients' long-term health? Research and consensus have established that the annual well-woman visit be organized around clinical areas of concern, comprising 7 primary intervention areas and 3 optional areas of general health (**TABLE 2**). In addition, ObGyns are well-positioned to add several areas of counseling, support, and intervention:

- lifelong contraception management and planning
- pre-pregnancy counseling
- prevention of sexually transmitted infection
- identification of sexual concerns
- management of menopause.

Prevention of cervical Ca. With approval last year of the vaccine against several HPV types, we are in an unprecedented position to recommend vaccination against HPV—and other diseases.

Chlamydial infection. "Grade-A" evidence supports annual screening for *Chlamydia trachomatis* for 1) all sexually active women 25 years and younger and 2) older women who engage in high-risk behavior (eg, more than one sex partner).

Pap smear and HPV typing. ACOG and the American Cancer Society recommend annual Pap smear testing beginning 3 years after the onset of sexual activity and continuing until 30 years of age. Routine testing for high-risk HPV subtypes may be undertaken with the Pap smear for women older than 30 years.

For most women who test negative for HPV and who have negative Pap smear cytology, Pap smear testing should be repeated no more often than every 3 years. Women who are positive for a high-risk HPV type despite a negative Pap smear should continue to be screened annually with cytology and HPV testing.

Breast health. Many groups recommend training women to perform monthly breast self-examination (BSE), although the USPSTF states that there is "insufficient evidence to recommend for or against" BSE. All groups do, however, advise an annual breast examination by a clinician, along with annual or biennial mammography beginning at 40 years of age and annual mammography beginning at 50 years.

Although many women do detect a breast lump when performing a BSE, it is unclear whether BSE improves survival from breast cancer. That's because many lumps that women discover are benign.

Generally, therefore, I tell patients to pay attention to their breasts as they would other body parts: Don't ignore an obvious change but don't feel it is necessary to perform a standardized examination of the breasts monthly; evidence just does not support such a need.

Cardiovascular health. Assess blood

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I tell patients not to ignore an obvious change in the breast—but also that they should not feel it's necessary to perform a standardized breast exam monthly

pressure in every patient at every visit. Persistently high readings (>130/80 mm Hg) should prompt action—whether lifestyle modification or medication. Many physicians are slow to treat young women with so-called labile or borderline hypertension because the onset of cardiovascular disease is generally at an older age in women, but evidence shows that women suffer from proportionately more strokes at a young age than men do. Aggressive management of persistent hypertension may improve outcome.

- **Aspirin therapy is recommended for prevention of stroke** in women 45 to 65 years who are at risk. Do not recommend aspirin routinely, however, for women younger than 65 years as a means of preventing myocardial infarction.

ObGyns are in an excellent position to identify women, at an early age, who have metabolic syndrome—when intervention may truly have an impact on the disorder. When you see a patient who has adolescent-onset obesity, oligomenorrhea, acne, and hirsutism, you should not only manage her abnormal bleeding and infertility but also screen her for hyperlipidemia and glucose intolerance.

- **Perform a baseline lipid profile** on all women older than 45 years. A woman who has a risk factor for cardiovascular disease—smoking, hypertension, obesity or overweight, a family history of early-onset cardiovascular disease—should be screened at any age.
- **Screening may be performed as a random lipid profile** to eliminate the barrier of returning after an 8-hour fast. Only women who have a significant abnormality need to return for repeat testing after an overnight fast.
- **I usually intervene with lifestyle modification recommendations** first—more exercise, weight loss, more monounsaturated fats and omega-3 fats in the diet—and have the patient return for a fasting lipid profile after 3 to 6 months.

Although quality evidence is lacking on the benefit of counseling about weight reduction and exercise, my experience is that providing a message to patients consistently about a healthy lifestyle is more effective than almost any other medical intervention. To have an impact on cardiovascular health, however, it is imperative that we have basic knowledge about nutrition and exercise physiology—which were not taught in medical school.

It is, clearly, not useful to simply tell a patient to lose weight. Evidence does support sustained weight loss when a person participates in an organized program, such as Weight Watchers. Even moderate weight loss is associated with a reduction in the risk of hypertension, an improvement in lipid levels, and a substantial reduction in the risk of breast cancer.

I find that this last statistic—namely, that lifetime physical activity and maintenance of normal body weight is associated with a 20% to 40% reduction in the risk of breast cancer compared with the risk in women who do not exercise or who gain 10 kg or more above their high school weight—is a huge motivator. Why? It's well-known that women are more concerned about breast cancer than about cardiovascular disease—even though statistics demonstrate that heart disease is the leading cause of death among women.

Diabetes. Women who have a history of gestational diabetes also have a markedly increased risk of type II diabetes within 5 years of the pregnancy. Clearly, these women, as well as those who are obese, have a strong family history of diabetes, or have abnormal lipid levels, should be screened with a random glucose measurement. Women who suffer chronic monilial infection should also be assessed for diabetes.

Colorectal cancer. The second leading cause of cancer death and the fourth most common cancer in the United States carries the same risk for women as it does for men. Polyps and cancers are more likely to present on the right (ascending) side of the colon in women, however, making screening with flexible sigmoidoscopy potentially less useful.

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Flexible sigmoidoscopy may be less useful in women because polyps and cancers are more likely to present on the right (ascending) side of the colon

Sixty-five percent of the US population has not been adequately screened for colorectal cancer. This is regrettable, because good-quality data support an association between screening and a reduction in mortality—even simple screening with annual fecal occult blood testing. Ideally, colon cancer testing in people of average risk should begin at 50 years with either

- colonoscopy every 10 years
- flexible sigmoidoscopy every 5 years with or without annual fecal occult blood testing
- dual-contrast barium enema every 5 years
- fecal occult blood testing annually or
- perhaps, virtual colonoscopy or stool-based DNA testing for patients who decline traditional evaluation.

Data demonstrate a significant reduction in risk of death from colorectal cancer with annual fecal occult blood testing. Although a single test is only 30% to 50% sensitive (like a Pap smear), a program of repeated annual testing detects colorectal cancer in 92% of cases. Offered annually, fecal occult blood testing reduces deaths from colorectal cancer by 33% at 13 years.

Osteoporosis. For most women, screening for osteoporosis should begin at 65 years with a test of bone mineral density. Younger women who have a significant risk factor (weight, less than 127 pounds; hyperthyroidism; steroid use; a strong family history) might benefit from screening at an earlier age. All women who take more than 7.5 mg of prednisone daily or who have sustained a nontraumatic fracture should be treated to prevent osteoporosis regardless of findings on a dual energy x-ray absortiometry (DEXA) scan.

(Note: It is vital for you to provide osteoporosis screening to Medicare patients because this is 1 of only 2 office-based performance measures in the voluntary Medicare pay-for-performance list for 2007 that are applicable to gynecology practice; the other is screening for incontinence.)

Depression. We know that depression is more common, and tends to present with more physical complaints, in women than in men. Any patient who has vague somatic symptoms, chronic pain, fatigue, decreased libido, and sleep disturbances, or such "hormonal" complaints as premenstrual syndrome and hot flashes, should be screened for depression.

I have found that the Beck Depression Inventory is easy and quick to administer if indicated. This screening instrument can be downloaded from several Web sites (search the terms Beck/Depression/Inventory). For patients who screen positive, provide a resource sheet that includes a listing of specialist referrals and local depression hotline numbers.

Plus 3 at your discretion

The USPSTF has listed 3 optional areas for annual assessment: thyroid disease, bladder health, and domestic violence.

Thyroid. Because thyroid abnormalities are more common in women and because they may have an impact on the regularity of the menstrual cycle and on weight and hair loss, it seems sensible and appropriate to screen on a selected basis with a test of thyroid-stimulating hormone.

Incontinence. You should definitely include this problem in the review-of-systems questionnaire. Doing so will not only help the patient identify an embarrassing problem that she may be reluctant to bring up, but will also help drive additional services in your practice—such as urodynamic evaluation and surgery.

Build a relationship

The annual visit should reinforce the physician–patient relationship by educating women about the appropriate screening tests and supporting them as active participants in their health care. Take a consistent, balanced approach that complies with guidelines but that also addresses the patient's concerns by incorporating education and appropriate interventions. ■

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Initiate screening for osteoporosis for most women with a test of bone mineral density at 65 years

Reference

1. Oboler SK, LaForce FM. The periodic physical examination in asymptomatic adults. Ann Intern Med. 1989;110:214–226.