

2020 GYN ~~UPDATES~~

ARE WE MAKING PROGRESS?
MENARCHE TO MENOPAUSE

LISA LEWIS, DO, FACOG, MPH

ROME
REGIONAL GYNECOLOGIC
MEDICAL EDUCATION

2020 ROCKY MOUNTAIN
Vail, CO, March 5 – 8, 2020

COLORADO
SOCIETY OF GYNECOLOGIC MEDICINE

CONFLICT OF INTEREST DISCLOSURE:

I have no conflicts and disclose that:

- I anticipate referencing the unlabeled / unapproved use(s) of VARIOUS CONTRACEPTIVE drug(s) for the following use:
 - MENOPAUSE
 - CYCLE CONTROL

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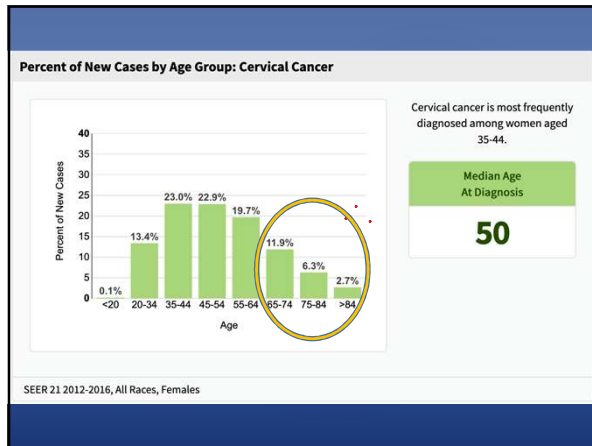
2018 PAP GUIDELINES –
CAN WE DO BETTER?

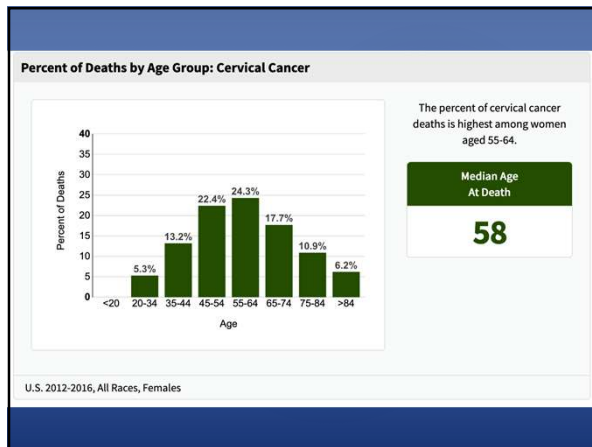
The pap smear is still considered one of the best
cancer screening tests available today.

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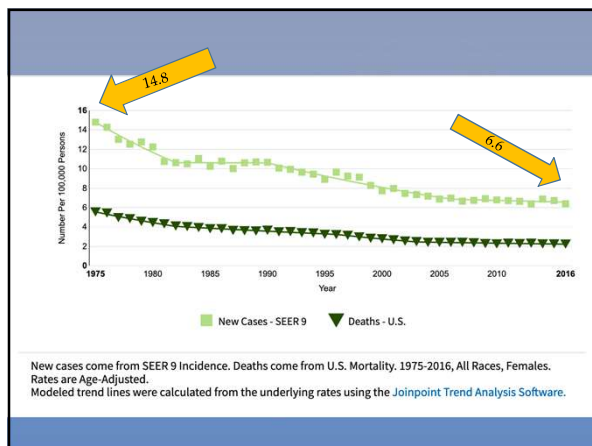


Table 1: Cervical cancer screening: WHEN TO SCREEN

Age to begin	21
Method and intervals, by age	Ages 21-65: cytology every 3 years or Ages 21-29: cytology every 3 years, then Ages 30-65: cytology plus hrHPV testing every 5 years (co-testing) Co-testing is reserved for women ages 30-65 wanting to lengthen their screening interval to every 5 years.
<p>These are 2012 recommendations by the USPSTF, ACOG and ACS.</p> <p>hrHPV indicates high-risk human papillomavirus.</p> <p>*Recommendations apply to women with no prior diagnosis of cervical intraepithelial neoplasia grade 2 or a more severe lesion or cervical cancer, women who are not immunocompromised (e.g., HIV infected) and women with no in utero exposure to diethylstilbestrol.</p> <p>Only among women with 3 consecutive negative cytology results or 2 consecutive negative cytology plus hrHPV tests within 10 years before cessation of screening, with the most recent test performed within the last 5 years. Screening should not resume after cessation even if a woman acquires new sexual partners. Routine screening should continue for at least 20 years after treatment of CIN2 or CIN3, even if this extends screening past age 65.</p>	
Special populations	Screen as above
Pregnant women	Screen as above
After total hysterectomy	<p>If no prior CIN2, 2/3 or 3: Screening should not be performed.</p> <p>If prior CIN2, 2/3 or 3: End screening after 3 normal annual vaginal cytology tests (2003 ACOG recommendation).</p>
Women with HIV infection or immunocompromise	Annual screening after 2 normal cytology tests 6 months apart in the year following initial HIV diagnosis or immunocompromised state
After diagnosis and treatment of cervical cancer	Surveillance as per gynecologic oncology protocols
<p>CIN indicates cervical intraepithelial neoplasia.</p> <p>*2012 ACOG recommends cytology every 3 years for 20 years after the initial CIN2+ treatment and post-treatment surveillance.</p>	

202.25: personal use immune suppressing therapy

Savaya & Smith-McCune, SFGHUSCF/SFDPH, 2018

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Table 2. Management of initial screening test results

• Unsatisfactory cytology	Repeat cytology in 2-4 months
• Satisfactory cytology, but no endocervical cells	Repeat cytology in 3 years*
• Atypical squamous cells, undetermined significance (ASU)	Routine screening in 3 years
• LSIL, hrHPV negative	Pre-menopausal: No action
• Benign-appearing endocervical cells	Post-menopausal: Endometrial biopsy.
• ASC-US, hrHPV unknown	Ages 21-24: Cytology in 12 months (colposcopy for ASC-H or HSIL+) and at 24 months (colposcopy for any abnormality). If all normal, routine screening.
• Normal cytology, hrHPV positive, HPV 16/18 negative	Ages 25+ Cytology in 12 months. Colposcopy for any abnormality. If normal, resume routine screening.
• Low-grade squamous intraepithelial lesion (LSIL), hrHPV negative	Cytology plus HPV testing in 12 months. Colposcopy for any abnormality. If both normal, repeat cytology plus HPV testing in 3 years.
• ASC-US, hrHPV positive	Ages 21-24: Cytology in 12 months (colposcopy for ASC-H or HSIL+) and at 24 months (colposcopy for any abnormality). If all normal, routine screening.
• Normal cytology, hrHPV positive on 2 consecutive tests	Age 25+ Colposcopy
• LSIL, hrHPV positive or unknown	Colposcopy*
• High-grade squamous intraepithelial lesion (HSIL)	Colposcopy with endocervical curettage, endometrial biopsy if abnormal bleeding, chronic anovulation or age 35+
• Atypical squamous cells, cannot exclude HSIL (ASC-H)	
• Atypical glandular cells (AGC)*	
• Adenocarcinoma in situ	

hrHPV indicates high-risk human papillomavirus. HSIL+ indicates HSIL, AGC, AIS or cancer.

*2012 ACOG/ASCCP: cytology plus hrHPV testing preferred over repeat cytology alone.

*Colposcopy should be performed even if hrHPV is negative. Endocervical curettage should not be performed in pregnancy.

*If atypical glandular cells are specified as endometrial, endometrial biopsy is indicated.

Pregnant women

ASC-US: Age 21-34: manage as per non-pregnant women. Age 35+: if colposcopy indicated, may defer to 6 weeks post-partum.

LSIL: Age 21-34: manage as per non-pregnant women. Age 35+: colposcopy is recommended but may be deferred to 6 weeks post-partum.

Women with HIV infection: manage as per average-risk women (as per ASCCP 2012)

All patients should be advised about smoking cessation and HIV testing should be offered.

Savaya & Smith-McCune, SFGHUSCF/SFDPH, 2018

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Table 3. Management after initial colposcopy

Indication for initial colposcopy	Findings at colposcopy	
	No lesion, normal biopsy or CIN1	CIN2, 2/3, 3
Normal cytology, hrHPV positive on 2 consecutive tests	Age 25+: Cytology plus hrHPV testing in 12 months; colposcopy for any abnormality. If both normal, routine screening.	see Table 4
Normal cytology, hrHPV positive, HPV 16/18 positive	Ages 21-24: Cytology alone in 12 months (colposcopy for ASC-H or HSIL+) and at 24 months (colposcopy for any abnormality). If all normal, routine screening.	
Atypical squamous cells of undetermined significance (ASC-US) on 2 consecutive tests	Cytology plus hrHPV testing in 12 and 24 months; colposcopy for any abnormality. If all normal, routine screening.	
ASC-US, hrHPV positive	Colposcopy and cytology at 6 and 12 months. If colposcopy adequate and endocervical curettage negative: If all normal, routine screening.	
Low-grade SIL (LSIL)	Diagnostic excisional procedure, if colposcopy inadequate*	
Atypical glandular cells (AGC), not otherwise specified	Diagnostic excisional procedure†	
High-grade SIL (HSIL)		
Atypical squamous cells, cannot exclude HSIL (ASC-H)		
Atypical glandular cell, favor neoplasia		
Adenocarcinoma in situ		

CIN indicates cervical intraepithelial neoplasia. hrHPV indicates high-risk human papillomavirus testing. SIL indicates squamous intraepithelial lesion. HSIL+ indicates HSIL, AGC, AIS or cancer.

*2012 ACOG/ASCCP: for women aged 25+, cytology plus hrHPV testing in 12 and 24 months; colposcopy for any abnormality. If all normal, repeat cytology plus hrHPV testing in 3 years. If cytology and HPV testing at 3 years normal, routine screening.

†Review of prior cytology, histology and colposcopic findings may be warranted, especially when potential risks of excision may exceed benefit.

Excisional procedures are deferred in pregnant women to the postpartum period unless cancer is suspected.

*2012 ACOG/ASCCP: If all normal, cytology alone (women under 30) or cytology plus hrHPV testing (women 30+) in 3 years. If testing at 3 years normal, resume routine screening.

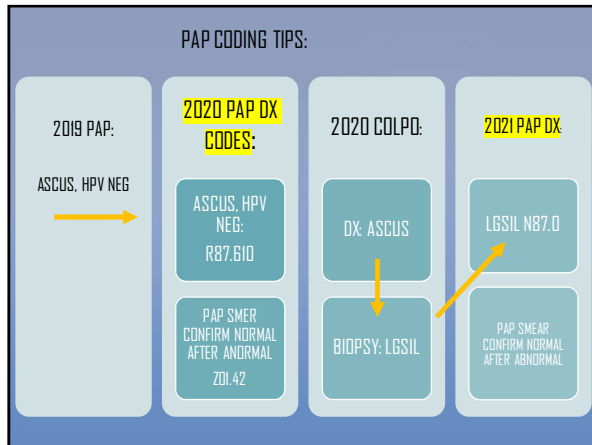
All patients should be advised about smoking cessation and HIV testing should be offered.

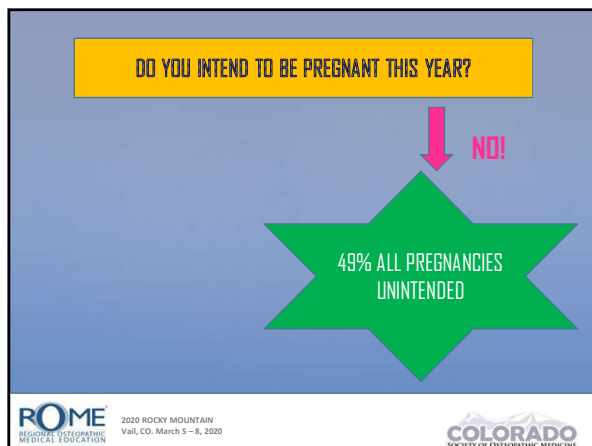
Savaya & Smith-McCune, SFGHUSCF/SFDPH, 2018

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Table 4. Choosing treatments for CIN2*, CIN2/3* and CIN3	
Ablation	Cryotherapy Use if the following criteria met: <ul style="list-style-type: none">• adequate colposcopy• lesion(s) completely visible, not covering more than 75% of the ectocervix and can be covered entirely with the cryoprobe• under age 40 Laser Use as for cryotherapy and for large (>2 cm) and/or multifocal lesions, with or without vaginal involvement.
Excision	Loop excision Use if criteria for ablation not met. Cone biopsy Use if criteria for ablation not met and instead of loop excision if suspicion for malignancy or cervical architecture distorted (e.g., prior cervical treatments, severely atrophic cervix).
<div><p><small>*In women at ongoing risk of CIN2 and CIN3 (but not CIN1), colposcopy and cytology every 12 months for up to 24 months is acceptable if colposcopy is adequate. Routine screening may resume after 2 normal cytology tests and colposcopy and a normal cytology plus HPV test a year later. (We recommend) ablation in women under age 40 when criteria are met.</small></p><p><small>*Cryotherapy failure rates increase with age and exceed 30% over a 6-year period in women aged 40+ treated by CIN2.</small></p></div>	
Table 5. Follow-up after treatment of CIN2, CIN2/3 and CIN3	
Hysterectomy	Screening may end after 3 normal annual vaginal cytology tests (2003 ACOG recommendation)*
Cryotherapy or laser ablation, loop excision or cone biopsy with negative margins	Cytology with or without colposcopy at 6 months, followed by cytology at 12 months and then annual cytology for at least 20 years*
Loop excision or cone biopsy with positive margins	Cytology and endocervical curettage (non-pregnant women) with or without colposcopy at 6 months, followed by cytology at 12 months and then annual cytology for at least 20 years.
2012 ACOG/ASCCP recommendation	Cytology alone every 3 years for 20 years after the initial CIN treatment and post-treatment surveillance
2012 ACOG/ASCCP recommendation	Cytology plus HPV testing in 12 and 24 months, colposcopy for any abnormality. If all normal, cytology plus HPV testing in 5 years. If cytology and HPV testing in 5 years normal, routine screening.
Table 6. Follow-up after treatment of adenocarcinoma in situ	
Hysterectomy	Annual cytology. After 3 consecutive normal tests, cytology may be performed every 3 years.
Cone biopsy	Colposcopy with cytology, HPV testing and ECC in 6 months, then cytology and ECC 12 and 18 months later followed by cytology and ECC every year until hysterectomy. Colposcopy for ASC+.
All patients should be advised about smoking cessation and HIV testing should be offered.	
Savaya & Smith-McCune, SF GHUSP/SFDPH, 2018	















NEW PRODUCTS

A WORD ABOUT PCOS



2020 ROCKY MOUNTAIN
Vail, CO. March 5 – 8, 2020



SOCIETY OF ENDOCRINOLOGISTS

	OLIGO-ANOVULATION	HYPER-ANDROGENISM	HYPER-ANDROGENEMIA
CONGENITAL ADRENAL HYPERPLASIA (LATE)	×	×	×
ANDROGEN TUMOR: OVARY; ADRENALS	×	×	×
CUSHING'S SYNDROME	×	×	×
HYPERPROLACTINEMIA	×		
HYPOTHYROID	×	I ×	
IATROGENIC: ANDROGENIC; ANTIEPILEPTIC; ANTIDEPRESSANTS	×	×	
SEVERE INSULIN RESISTANCE	×	×	×
PUBERTY	×	×	

DIAGNOSTIC CRITERIA FOR PCOS – 3 DEFINITIONS:

	NIH 1990	ROTTERDAM '03	AE&PCOS '06
LESS THAN 8 PERIODS PER YEAR (>35D)	✗	ANY 2 OF 3	✗
ELEVATED ANDROGENS/HYPER-ANDROGENISM	✗		✗ OR ✗
>12 FOLLICLES IN AT LEAST ONE OVARY (2-9MM)			✗

NIH: NATIONAL INSTITUTE OF HEALTH CLINICAL CRITERIA 1990

ROTTERDAM CLINICAL CRITERIA 2003

AE & PCOS: ANDROGEN EXCESS AND POLYCYSTIC OVARIAN SYNDROME SOCIETY CRITERIA 2006

PUBERTY:

❖ **ACNE** = INCREASED DHEA/ANDROGENS > FOLLICULAR OCCLUSION AND INFLAMMATION, INCREASED DHEAS = INCREASED ACNE

❖ **REGULAR PERIODS:**

❖ TAKE ON AVERAGE 12-18 MO IF PUBERTY STARTS AROUND 9.6 YEARS.

❖ IF PUBERTY STARTS AT/AFTER AGE 13, CAN TAKE 4.5 YEARS FOR 50% TO HAVE REGULAR CYCLES



Psychological Aspects of Polycystic Ovary Syndrome pp 63-89 | Cite as

Anxiety and Other Psychological Issues in PCOS

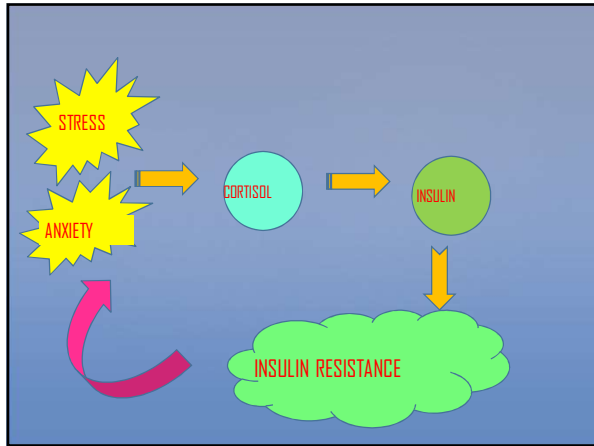
Authors Authors and affiliations

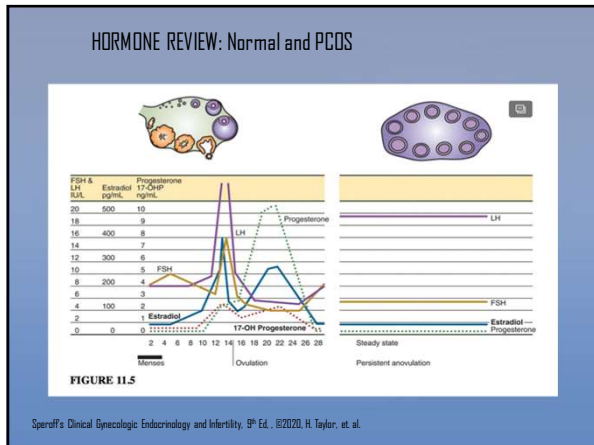
John A. Barry

Chapter
First Online: 16 November 201944
Downloads

Abstract

Anxiety is usually seen as less important than depression in polycystic ovary syndrome (PCOS), but this chapter shows that the secondary status of anxiety is misplaced. **Firstly**, anxiety is probably a more clinically significant issue than depression in PCOS. **Secondly**, the causes of anxiety are probably more complex than they are for depression in PCOS, involving a greater number of psychological pathways. **Thirdly**, there is the interesting question of how much anxiety and stress can be a cause as well as a product of PCOS. This chapter also examines the impact of PCOS on quality of life (QoL), and describes some of the new and lesser-researched psychological issues that might be associated with PCOS, such as autism spectrum disorder (ASD).







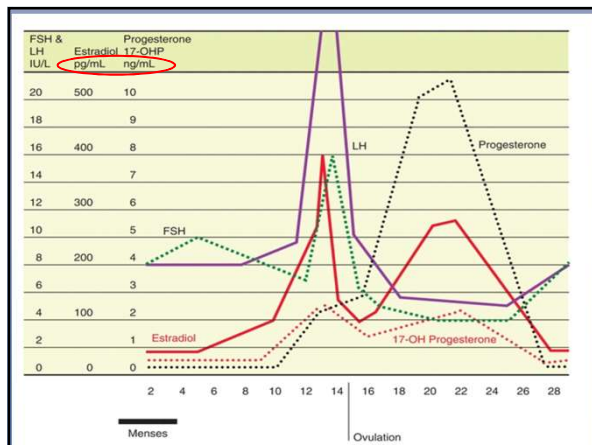
HORMONE UPDATES

How many picograms are in a nanogram?

1,000 pg = 1 ng

1,000 mg	10^3
100,000mcg	10^6
1,000,000,000 ng	10^9
1,000,000,000,000 pg	10^{12}


 2020 ROCKY MOUNTAIN
 Vail, CO. March 5 – 6, 2020








PROGESTERONE magnitude higher dose

PROGESTERONE CREAM

- Progesterone molecule still may be too big to absorb through skin
- OTC progesterone cream can only contain 0.016% or can not be sold OTC. (16mg/100grams)



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WHAT ABOUT TESTOSTERONE?

TABLE 17.4

Blood Production Rates of Steroids ¹⁰⁴			
	Reproductive Age	Postmenopausal	Oophorectomized
Androstenedione	2–3 mg/day	0.5–1.5 mg/day	0.4–1.2 mg/day
Dehydroepiandrosterone	6–8	1.5–4.0	1.5–4.0
Dehydroepiandrosterone sulfate	8–16	4–9	4–9
Testosterone	0.2–0.25	0.05–0.18	0.02–0.12
Estrones	0.350	0.045	0.045
Changes in Circulating Hormone Levels at Menopause ^{10,105}			
	Pre-menopause	Postmenopause	
Estradiol	40–400 pg/mL	10–20 pg/mL	
Estrone	30–200 pg/mL	30–70 pg/mL	
Testosterone	20–80 ng/dL	15–70 ng/dL	
Androstenedione	60–300 ng/dL	30–150 ng/dL	

Speroff Clinical Gynecologic Endocrinology and Infertility; Taylor, H. et. al, ©2020.



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2020 US and International Testosterone Data:

Testosterone levels decline in reproductive years and are maintained after age 65	LEVEL I, GRADE B
Testosterone therapy, in doses that approximate physiological testosterone concentrations for premenopausal women, exerts a beneficial effect on sexual function	LEVEL I, GRADE A
Available data show no effect of testosterone therapy on general wellbeing	IA
The available data do not support an effect of testosterone treatment on bone mineral density at the spine, total hip, or femoral neck at 12 months	IA
No statistically significant effect of testosterone administered in physiologic doses has been demonstrated on lean body mass, total body fat, or muscle strength	IA
The only evidence-based indication for the use of testosterone in women is for the treatment of postmenopausal women who have been diagnosed as having HSDD after formal biopsychosocial assessment	IA
Use of any testosterone preparation that results in supraphysiologic concentrations of testosterone, including pellets and injections, is not recommended	Expert opinion

ERAS: EARLY RECOVERY AFTER SURGERY

AND PRE-SURGERY CLINICAL TOOLS

ERAS REDUCES HOSPITAL STAY

ACA/AHA PREOP EVALUATION ALGORITHM: WHO NEEDS CLEARANCE

FIGURE 1
Preoperative evaluation algorithm^{1,2}

1. American College of Surgeons. ACS NSQIP. American College of Surgeons National Surgical Quality Improvement Program. 2019. Available from: <https://www.facs.org/quality-programs/nsqip>. 2. American College of Surgeons. ACS NSQIP. American College of Surgeons National Surgical Quality Improvement Program. 2019. Available from: <https://www.facs.org/quality-programs/nsqip>.

REVISED CARDIAC RISK INDICATOR:

RCRI

Revised Cardiac Risk Index (RCRI)

- CAD (MI, + stress, use NTG, CP chv angina, Q-waves)
- CHF
- CVA/TIA
- DM (requiring insulin)
- CKD (Cr > 2.0 mg/dL)
- High Risk Surgery (suprainguinal vascular, intraperitoneal, intrathoracic)

Score	% of MACE
0	0.4%
1	0.9%
2	6.6%
3+	11%

17 Challenges in Perioperative Evaluation

UCSF

UCSF CME: 'WHAT DOES THE EVIDENCE TELL US 2018. STETSON. PREOP EVAL

NSQIP: <https://riskcalculator.facs.org/RiskCalculator/PatientInfo.jsp>

Surgical Risk Calculator

AMERICAN COLLEGE OF SURGEONS
Improving Quality. Higher Standards. Better Outcomes.

Home About FAQ ACS Website ACS NSQIP Website

Enter Patient and Surgical Information

1 Procedure

Begin by entering the procedure name in CPT code. One or more procedures will appear below the procedure box. You will need to click on the required procedure to properly submit it. You may also search using two words (or two partial words) by placing a "+" in between, for example: "cholecystectomy + cholangiolithotomy"

Reset All Selections

2 Are there other potential appropriate treatment options? Other Surgical Options Other Non-operative options None

Please enter as much of the following information as you can to improve the best risk estimate. A high estimate will still be generated if you cannot provide all of the information below.

Age Group

Under 55 years

55-64 years

65-74 years

75-84 years

85+ years

Sex

Female

Male

Functional Status

Independent

Intermediate

Dependent

Emergency Case

No

Yes

ASA Class

I

II

III

IV

V

Steroid use for chronic condition

No

Yes

Anesthesia within 30 days prior to surgery

No

Yes

Systemic Drips within 48 hours prior to surgery

No

Yes

Distance

Yes

No

Hypertension requiring medication

No

Yes

Compensatory Heart Failure in 30 days prior to surgery

No

Yes

Diabetes

No

Yes

Current Smoker within 1 Year

No

Yes

History of Severe COPD

No

Yes

Dialysis

No

Yes

Acute Renal Failure

No

Yes

When to Use

Patients undergoing surgery under general, neuraxial, or regional anesthesia.

Age, years

≤50 0 51-80 +3 >80 +16

Preoperative SpO₂

≥96% 0 91-95% +8 <90% +24

Respiratory infection in the last month
(either upper or lower [i.e., URI, bronchitis, pneumonia], with fever and antibiotic treatment)

No 0 Yes +17

Preoperative anemia (Hgb ≤10 g/dL)

No 0 Yes +11

Surgical incision

Peripheral 0

Upper abdominal +15

Intrathoracic +24

Duration of surgery

<2 hrs 0

2-3 hrs +16

>3 hrs +23

Emergency procedure

No 0 Yes +8

ARISCAT: PULMONARY RISK

<https://www.mdcalc.com/ariscat-score-postoperative-pulmonary-complications#use-cases>

0-25	LOW RISK: 1.6% risk
26-44	Intermediate risk: 13.3% risk
45-123	High risk: 42.1% risk

Sleep apnea: STOP-BANG

STOP: SYMPTOMS

SNOORING LOUDLY?	Y/N
TIRED - FALL ASLEEP ANYTIME?	Y/N
OBSERVED - ANYONE SEE YOU STOP BREATHING?	Y/N
PRESSURE - DO YOU HAVE HIGH BP?	Y/N

BANG: OBSERVATIONS:

BMI >35	Y/N
AGE > 50	Y/N
NECK SIZE: MALE: OVER 17 FEMALE: OVER 16	Y/N
GENDER: MALE?	Y/N

STOP BANG RESULTS:

OSA - Low Risk : Yes to 0 - 2 questions
 OSA - Intermediate Risk : Yes to 3 - 4 questions
 OSA - High Risk : Yes to 5 - 8 questions
 or Yes to 2 or more of 4 STOP questions + male gender
 or Yes to 2 or more of 4 STOP questions + BMI > 35kg/m²
 or Yes to 2 or more of 4 STOP questions + neck circumference 17 inches / 43cm in male or 16 inches / 41cm in female

GERIATRICS - SPECIAL CONSIDERATIONS

- Cognitive Baseline & Delirium Risk
- Functional capacity
- Polypharmacy
- Nutrition
- Functional: one of strongest predictors of postop mortality, delirium, infection, need for Skilled Nursing facility

- Education, expectations, goal setting
- Family and Care Taker education
- Advanced Directives

UCSF WHAT DOES THE EVIDENCE TELL US? 2018: CHALLENGES IN THE PREOP EVALUATION, STEVENSON

TIMED UP AND GO TEST: TUGT

<15 SECONDS

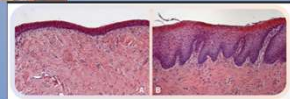
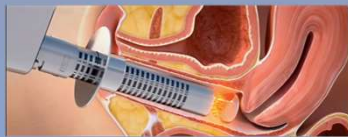
- ❖ Rise from chair w/o pushing off
- ❖ Walk 10 feet
- ❖ Turn around
- ❖ Return to chair
- ❖ Sit down

THE FUNCTIONAL SCREEN

USF: WHAT DOES THE EVIDENCE TELL US? 2018: CHALLENGES IN THE PREOP EVALUATION, STEVENSON

NON-HORMONAL TREATMENTS FOR VAGINAL ATROPHY....

NEW GADGETS ON THE HORIZON



ATROPHIC VAGINITIS TREATMENTS
