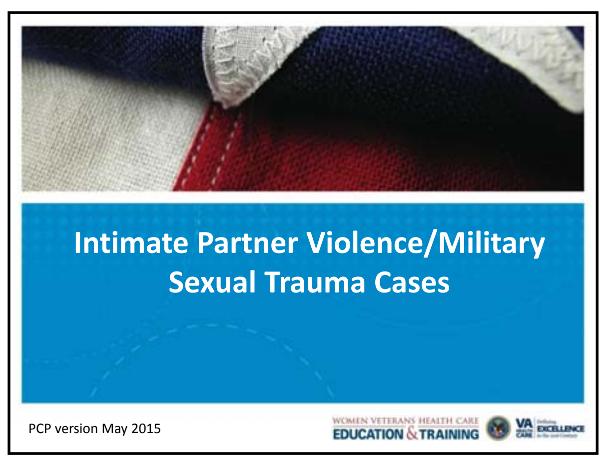
CASE STUDY SLIDES



Intimate Partner Violence/Military Sexual Trauma Cases

PCP version May 2015

WOMEN VETERANS HEALTH CARE EDUCATION & TRAINING

Case Study 1

Anita, a 26-year-old female, presents to the clinic for follow up from a recent ED visit at which she was evaluated for a sprained wrist sustained during a fall.

While reviewing the schedule before clinic, you notice that she has been seen multiple times in the ED for various orthopedic complaints including knee pain and an ankle sprain, and also for a head injury. She has also had multiple gap visits in clinic for chronic abdominal pain. That work-up has been negative.

Case Study 1 (continued)

As you greet Anita, you notice her bandaged wrist and a small bruise on the side of her face. She does not make eye contact.

Table Discussion

Would you ask about underlying circumstances of the injury at this point?

If so, how?

If not, when?

E-HITS Screen

1. Has your partner ever physically hurt you in the past 12 months?
   - Never
   - Rarely
   - Sometimes
   - Often
   - Frequently
2. Has your partner ever insulted you in the past 12 months?
3. Has your partner ever threatened to harm you in the past 12 months?
4. Has your partner ever screamed or cursed at you in the past 12 months?
5. Has your partner ever forced you to have sexual activities in the past 12 months?

Scoring:
Range 5-25
Positive ≥7

Iverson et al. *J Gen Intern Med*, 2013.

Case Study 1 (continued)

You say to Anita…

Looking at your record, I see that you have been seen multiple times for injuries. In cases like yours, I get concerned that your symptoms (injuries) may have been caused by someone hurting you at home.

She starts to cry and admits that when her husband drinks, he gets angry if she has not cleaned up after the kids or doesn't have dinner ready. Then he hits her. He is always very sorry afterward and promises it will never happen again.

Case Study 1 (continued)

Anita tells you that her husband is in the waiting room. She now thinks that he is not going to stop, because it always happens again. No matter how careful she is and how hard she works, he always finds something that makes him angry. The violence has escalated and is occurring more frequently. He lost his job and is home all day and drinking much of the time.

Team Huddle

What if your nurse collected a lot of this information on intake?

How would you like your nurse to convey the information to you?

Case Study 1 (continued)

You proceed to evaluate Anita. You learn that she injured her wrist when her husband pushed her down during an argument. He is in the waiting room, and she's scared that he will find out that she told you about the violence.

You evaluate and address her physical injury. While she is not ready to leave the situation today, she wants to know about her options.

Table Discussion

What resources in the clinic could be offered Anita?

What resources could you direct her to for future use?

What are your local laws about reporting IPV?

IPV Resources

- Mental Health
- Social Work/local DV coordinator
- National Hotline
  - 24/7 phone support 1-800-999-SAFE (7233)
  - Live chat http://www.thehotline.org/what-is-live-chat/ 9AM to 7PM CST Monday to Friday
  - Blogs: *Survivor Series*, *Get Help Today*, *Offering Support*, *Healthy Love*, *DV on TV*
- womenslaw.org
  - Provides support and legal info (including state and federal laws) to victims of domestic violence and sexual assault

Case Study 2

Monica, a 28-year-old female G1P0A1, presents for a gap visit with a complaint of dysmenorrhea. She's asking for "something stronger than Midol". She states that her menstrual cycles are regular, occur about every 30 days, and last about 6 days. Her Paps have been normal, however she admits to not getting one in at least 3 years. She has never used birth control.

Her responses are abrupt and she brushes off questions that she sees as unrelated to her cramps.

Q1: What additional information about her dysmenorrhea would be helpful?

Q1: What additional information about her dysmenorrhea would be helpful?

- Has she tried any other medication or treatments for cramps?
- Other symptoms?
- Pregnancy history
  - Why did her pregnancy not go to term?
- Is she sexually active?
  - If so, is she monogamous? Is her partner monogamous?
  - What precautions does she take to prevent STI's?
- Social history
  - Smoking, drinking, drugs?

Case Study 2 (continued)

Monica becomes teary when asked about her pregnancy history. She's reluctant to talk about it and curls up into a ball in the chair.

Q2: What questions would you ask Monica at this point to probe further?

Q2: What questions would you ask Monica at this point to probe further?

- *It seems like you are upset, is there anything you would like to share?*
- *You seem upset, sometimes that happens when I've asked questions about a difficult experience. Is that happening to you right now?*

If she doesn't offer anything, consider using a lead-in such as *"Because violence is so common in the lives of women, we have begun asking all of our patients about it…"*

Case Study 2 (continued)

Your gentle probing elicits the information that Monica was raped by a fellow soldier about 18 months ago while in the military and she had an abortion for the resulting pregnancy.

She's been dating a co-worker on and off for several months, and states "so far I haven't let him touch me". She denies smoking and drugs, and drinks a couple of beers every night to help her fall asleep.

Q3: How would you prepare a patient in this kind of situation for a pelvic exam?

Q3: How would you prepare a patient in this kind of situation for a pelvic exam?

- Validate her story. Reassure her that the assault was not her fault.
- Help her anticipate the exam by describing the procedures
- Explain that the exam will stop upon her request
- Ask what she would find helpful to increase her comfort
- Explain the chaperone policy
- Brainstorm coping strategies she can employ
- Other steps:
  - Inform the provider of her history of MST
  - If triage occurs in a separate area, try to avoid putting her back in the waiting room

Q4: Monica had a normal pelvic exam. What would be your plan of care for her?

Q4: Monica had a normal pelvic exam. What would be your plan of care for her?

- Dysmenorrhea management
- Explore contraception options
- Consider referral to PCMHI or other MH providers
- Offer MST care coordinator referral
- Consider SW involvement

Do you know your local MST coordinator?

Wrap-up

Many women will deny being abused over and over to health professionals before they are finally ready to admit it.

It is especially important to tell women that the abuse is not their fault, that they don’t deserve to be treated this way, and that there are people who can help them.

Your role as a PACT member is not to solve this problem for the patient, but to provide support, validation, and connections to resources.

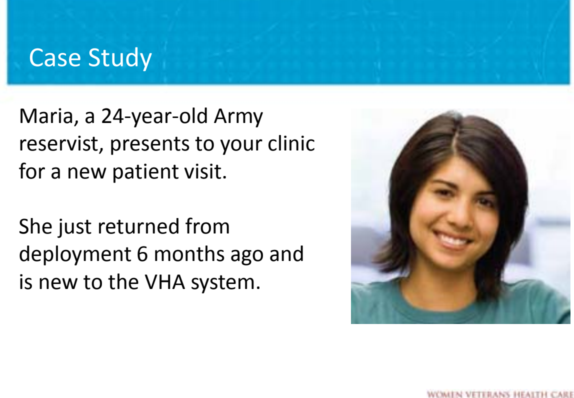


Table Discussion

In your facility, how would you ensure she gets access to services for which she is eligible?

Discussion Points

- Connect her to your post-deployment or OEF/OIF office
- Certain services need to be accessed soon after return. Dental example…

Apply for dental care within 180 days of discharge or release from of active duty (under conditions other than dishonorable) of 90 days or more during the Gulf War era	One-time dental care if a DD214 certificate of discharge does not indicate that a complete dental examination and all appropriate dental treatment had been rendered prior to discharge	Class II

Case Study (continued)

Although she is new to the VHA, Maria has already met with an OEF/OIF case manager. Her biggest health concern is that she has been having trouble sleeping.

As you query Maria's family history, she reveals that she grew up in a rural farming town in California. She is the oldest of three daughters. Her father, a truck driver, passed away in a work-related accident when she was 9 years old. Her mother has been working at a local elementary school. Maria joined the military at age 19 after completing her GED.

Q2: Based on her pre-military history, what are Maria's psychosocial risk factors?

Q2: Based on her pre-military history, what are Maria's psychosocial risk factors?

- Loss of her father
- Coping
  - Depending on how she learned to cope, this could be a strength or a weakness. Does she engage in risk-taking behavior? What about substance use?
- Why did she choose to complete a GED rather than attend high school?

Table Discussion

What do you want to know about Maria's deployment history?

Discussion Points

- Where was she deployed?
- What did she do while deployed?
- Any injuries or health issues sustained during deployment?
  - Trauma (combat, MST)
  - Exposures, fumes
  - Blasts, TBI, embedded fragments
  - Caffeine, tobacco, alcohol use

Case Study (continued)

Maria was deployed to Iraq for 12 months. Her responsibilities included driving trucks filled with equipment and supplies through hostile territories. She was the only female in her unit. She mentions being near a blast that tipped her truck over, but denies any personal injury - including embedded fragments - from this accident. She has recently returned to California.

Table Discussion

What are her deployment risk factors?

Discussion Points

- Extreme temperatures
- Heavy gear
- Driving long distances
- Moving heavy equipment
- Hygiene issues
- Combat exposure
- Interactions with male counterparts

Note: She was a truck driver, like her father. This might have increased her sense of danger and risk.

Q3: What would you like to know about Maria's post-deployment life?

Q3: What would you like to know about Maria's post-deployment life?

- What is her current military status/potential for redeployment?
- What is her living situation?
- How stable are her finances?
- What is her social support system?
- Is she in school? Working?
- How is she adjusting to civilian life?

Case Study (continued)

Maria has been home for about a year and is staying with her sister. She is in the reserves, but does not think she will be redeployed since there are members of her reserve unit who have not yet been deployed. She is taking some college courses online and is interested in forensics.

Case Study (continued)

Maria states that she had no health issues prior to deployment. Her family history is negative for any significant medical conditions. She denies any fevers, rashes, or GI complaints including nausea, vomiting, and diarrhea. Her depression, substance use, MST, and PTSD post-deployment screens are negative.

Maria complains of sleep disruption (difficulty falling asleep and staying asleep), headaches, and irritability.

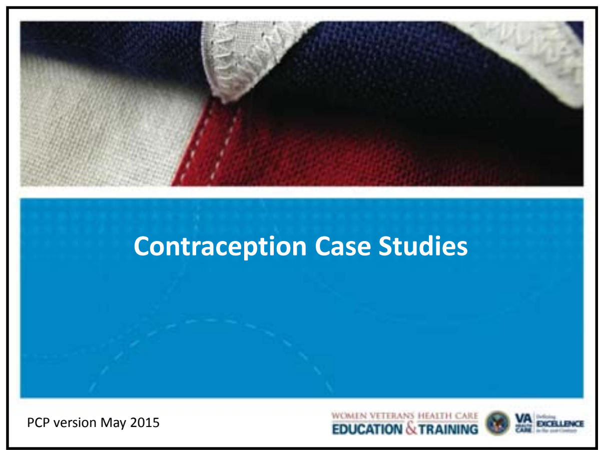
Q4: How would you address Maria's chief complaints?

Q4: How would you address Maria's chief complaints?

- Explore presence of TBI symptoms:
  - Memory problems?
  - Difficulty concentrating?
  - Headaches, loss of balance, dizziness?
  - Sleep problems?
  - Fatigue, irritability?
- Consider referral for TBI consultation
- Discuss basic symptom management for her sleep disruptions, headaches, and irritability

Summary: Addressing Post-Deployment Issues in Primary Care

- Patients are likely to first present in primary care. This is an important opportunity for:
  - Early detection
  - Risk reduction
  - Addressing mind and body health
  - Facilitating referrals
- Employ a screening pattern:
  - Pre-military life
  - Military experiences
  - Post-deployment experiences
  - Adjustment process vs. adjustment disorder
  - Substance use and disordered eating patterns



Contraception Case Studies

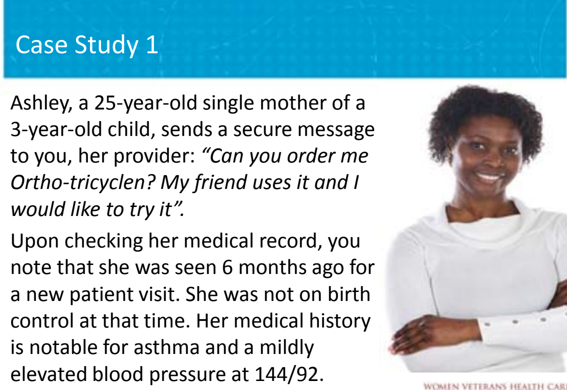
PCP version May 2015

WOMEN VETERANS HEALTH CARE EDUCATION & TRAINING

Case Study 1

Ashley, a 25-year-old single mother of a 3-year-old child, sends a secure message to you, her provider: *"Can you order me Ortho-tricyclen? My friend uses it and I would like to try it".*

Upon checking her medical record, you note that she was seen 6 months ago for a new patient visit. She was not on birth control at that time. Her medical history is notable for asthma and a mildly elevated blood pressure at 144/92.



Q1: Who triages questions like this on your team? Should she be seen?

Case Study 1 (continued)

It was decided that Ashley needs to come in for a visit to re-check her blood pressure prior to prescribing any hormonal contraception.

Vital signs: T 98.7, HR 76, BP 138/88, RR 16; 5'6", 210 lbs., BMI 33.9, pain 0/10

Q2: What additional information would be helpful?

Q2: What additional information would be helpful?

- LMP – Could she be pregnant now?
- Lifestyle – How predictable is her schedule?
- Partner – Mutually monogamous relationship?
- Reproductive – Past history and future childrearing plans?
- Medical history – Hypertension? VTE?
- Contraception history including likes and dislikes

Case Study 1 (continued)

Ashley notes that her menstrual period started 5 days ago. She has been sexually active in a monogamous relationship for 6 months and currently uses condoms for contraception.

During your discussion, Ashley states that she wants a more effective method of birth control. She thinks she may want to have another child in the next 1-2 years, but doesn't like using condoms. She and her partner sometimes forget to use them, and she notes "he doesn't like them anyway".

Her asthma is mild and intermittent, and she has a family history of hypertension. She is currently a graduate student.

Q3. What information do you NOT need prior to starting Ashley on hormonal contraception?

1. Blood pressure
2. Smoking history
3. Pap test and pelvic exam
4. History of migraines with auras
5. All of the above are needed prior to starting hormonal contraception

Q3. What information do you NOT need prior to starting Ashley on hormonal contraception?

1. Blood pressure
2. **Smoking history**
3. **Pap test and pelvic exam**
4. History of migraines with auras
5. All of the above are needed prior to starting hormonal contraception

Discussion Points

Prior to starting a COC, check:

- Blood pressure
- Family hx of thrombotic disorders?
- Migraines with aura?
- Smoking hx (not necessary for Ashley who is 25 yo, but important for women ≥ 35 or approaching this age)
- NOT necessary to do a Pap or pelvic exam prior to initiation
  - If she is due, however, now may be a good time
- Consider discussing HPV vaccine as she is under age 26

Q4. Extended cycle use of combined oral contraceptives (COCs) is useful to:

1. Reduce frequency of menses
2. Manipulate timing of menses
3. Control menorrhagia
4. Manage dysmenorrhea
5. All of the above

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3. Control menorrhagia
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5. **All of the above**

Discussion Points

Traditional COCs have 21 days of active pills and 7 days of placebo pills. Extended cycle COCs have 13-week cycles. Advantages of an extended cycle include:

- Only four periods a year
- Desirable for women who travel frequently or have menstrual-related problems (heavy bleeding, mood swings, acne)
- May be more effective than traditional COCs

Breakthrough bleeding can occur, especially at 9-12 weeks

NOTE: Many COCs can be taken continuously without placebo pills. This requires prescribing 4 pill packs for a 90-day supply. Monophasic pills must be used. Off-label use.

Case Study 1 (continued)

After a discussion of various contraceptive options, Ashley opts for a mid-dose COC. She wants to know when she should start the first dose.

Q5: Would you consider her for Quick Start?

Q5: Ashley is started on a mid-dose COC. Would you consider her for Quick Start?

Establish non-pregnancy:

- Have you given birth in the past 4 wks?
- Are you <6 mos postpartum AND exclusively breastfeeding AND free from menstrual bleeding since you had your child?
- Did your last menstrual period start within the past 7 days? ***Yes for Ashley!***
- Have you had a miscarriage or abortion in the past 7 days?
- Have you abstained from sexual intercourse since the start of your last menses?
- Have you been using a reliable contraceptive method consistently and correctly?

Q6. What are the key pieces of patient education for Ashley regarding OCPs?

Q6. What are the key pieces of patient education for Ashley regarding OCPs?

- Potential side effects (headache, nausea, spotting, breast tenderness, decreased libido)
  - Placebo-controlled trials have NOT found mood changes or weight gain to be more frequent with OCPs vs. placebo
- Use a non-hormonal back-up method for the first 7 days
- Habit formation
- What to do when one or more pills are missed
- Levonorgestrel (Plan B One-Step®) emergency contraception
- STI protection options

Case Study 1 (continued)

Ashley calls back in two months asking to discuss an urgent problem. The call is transferred to the RN care manager. Ashley states that she only took her OCPs for a month. She and her boyfriend broke up so she stopped taking them. She says she often forgot to take them anyway.

She had unprotected sex last night and "is really nervous about it".

Q7: Phone Triage - What could the RN Care Manager discuss with Ashley?

Q7: Phone Triage - What could the RN Care Manager discuss with Ashley?

- Consider taking Plan B
  - Potentially less effective given her elevated BMI
- Consider STI testing
- Any other reason she is scared?
  - (Any reason to suspect violence or that this was not consensual sex?)
- What are her ongoing contraceptive needs?

Table Discussion

How do you handle levonorgestrel EC prescribing in your clinic?

Does it require an in-person visit?

Do you ever order for patients in advance?

Case 1 (continued)

Ashley comes in that day for STI testing and levonorgestrel EC prescription. After further discussion with her provider, Ashley decides she needs to try an alternative contraception strategy.

Vital signs: T 98.8, HR 78, BP 140/86, RR 16; 5'6", 210 lbs., BMI 33.9, pain 0/10

Q8. Which of the following options might be less suitable for Ashley?

1. Ortho Evra® patch
2. NuvaRing®
3. Depo-Provera®
4. Implanon®

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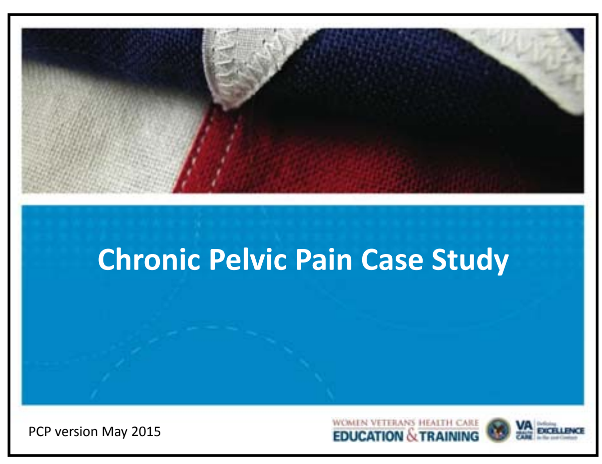
1. **Ortho Evra® patch**
2. NuvaRing®
3. **Depo-Provera®**
4. Implanon®

WOMEN VETERANS HEALTH CARE EDUCATION & TRAINING

Discussion Points

- Of the 15 pregnancies that occurred during the clinical trial of Ortho Evra®, five were in women greater than 90 kg. Thus, the patch may not be as effective in obese women. However, contraceptives are only effective if the patient will use them, so shared decision-making is very important in this case.
- Average weight gain with Depo-Provera® is 5.4 pounds in the first year. Weight gain is greater for women who are already obese.

WOMEN VETERANS HEALTH CARE EDUCATION & TRAINING



Chronic Pelvic Pain Case Study

PCP version May 2015

WOMEN VETERANS HEALTH CARE EDUCATION & TRAINING

Case Study

Your team MSA co-signs your team to a patient call note in CPRS which states:

" Patient calls and complains of abdominal pain. She asks for her provider to put in a consult to GI."

Table Discussion

How does your team handle this type of message during a busy clinic?

What should be looked for in the chart before calling the patient?

Case Study (continued)

Your nurse reviews the chart before returning the call and sees that the patient, Melissa, is a 28-year-old Veteran. She was last seen in the clinic 2 months ago for a similar complaint, and has made one subsequent trip to the ER also for abdominal pain. Melissa is G2P2 and is currently ordered for condoms.

Case Study (continued)

When the nurse returns her call, Melissa states that she has had lower abdominal pain for 6 months. She has tried acetaminophen and ibuprofen for pain but these medications have only helped a little.

She denies fever or chills. She reports no urinary symptoms, vaginal discharge, or new sexual partners. Her LMP was 3 weeks ago. She is not having nausea, vomiting, or diarrhea.

Q1: How soon does Melissa need to be seen? Where should she be evaluated?

Case Study (continued)

Melissa is offered an appointment later that week. On arrival, she appears uncomfortable but in no acute distress.

Vital signs: T 98.6, HR 78, BP 118/74, RR 18; 5'3", 123 lbs., BMI 21.8; pain 6/10

Case Study (continued)

Melissa states that the pain is in her left lower quadrant . It feels crampy and seems to be worse with her period and with intercourse, but also occurs at other times. She notes occasional constipation and bloating, and rare urinary frequency, but no pain on urination or defecation. She does have multiple daily bowel movements.

She is an otherwise healthy G2P2. She has had no surgeries and is currently in a monogamous relationship. She uses condoms for contraception. She reports no military or other sexual trauma.

Q3: Which of these exams would you perform to help diagnose Melissa's pain?

A. Abdominal exam

B. Pelvic exam

C. Rectal exam

D. All of the above

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C. Rectal exam

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Discussion Points

The physical exam should include an abdominal and pelvic exam that tries to locate and possibly reproduce the pain.

In this case, a rectal exam may also be useful. (A rectal exam is not normally recommended for screening as part of a routine pelvic exam.)

Q4: Which lab tests would you order?

Q4: Which lab tests would you order?

- Urine pregnancy
- Gonorrhea
- Chlamydia
- Wet mount
- Pap smear (if due)
- Urinalysis, urine culture
- Others?

Case Study (continued)

Melissa's pelvic exam is painful throughout. No specific areas are more painful than others.

Her urinalysis, wet mount, GC/Chlamydia test, and Pap smear are all normal. The pregnancy test is negative.

Q5: Which is the least likely cause of Melissa's pain?

A. Endometriosis
B. Adhesions
C. Irritable bowel syndrome (IBS)
D. Interstitial cystitis (IC)

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Discussion Points

Because Melissa has no history of prior surgeries or inflammatory disease, adhesions are the least likely cause of her pain.

Although the four most common cause of chronic pelvic pain are endometriosis, adhesions, IBS, and interstitial cystitis, other etiology must be considered:

- Chronic infection or pelvic inflammatory disease
- Adenomyosis
- Constipation
- Abdominal wall myofascial pain
- Other uterus, bladder, colon, musculoskeletal system conditions

Case Study (continued)

You review the lab results with Melissa and decide that she most likely has IBS. You initiate treatment with antispasmodics and dietary modification.

She initially does well, reporting an improvement in bowel movement frequency. However, she calls back 5 weeks later saying that her abdominal pain continues. She notes that the pain is worse with her periods and during intercourse

Table Discussion

Does she need to return for a clinic visit or would a phone visit suffice?

Q6: You suspect that Melissa also likely has endometriosis. How would you treat it at this time?

A. Narcotics
B. Oral contraceptives
C. Recommend endometrial ablation
D. Recommend hysterectomy
E. None of the above

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D. Recommend hysterectomy
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Discussion Points

- First-line treatment for endometriosis is an oral contraceptive
  - Continuous use may work better
- NSAIDS are most helpful for treating dysmenorrhea if they are started several days prior to the onset of menses
- Diagnosing and treating any concurrent depression, anxiety, or PTSD is also important

Case Study (continued)

Melissa sends a secure message that is assigned to you by your team MSA.

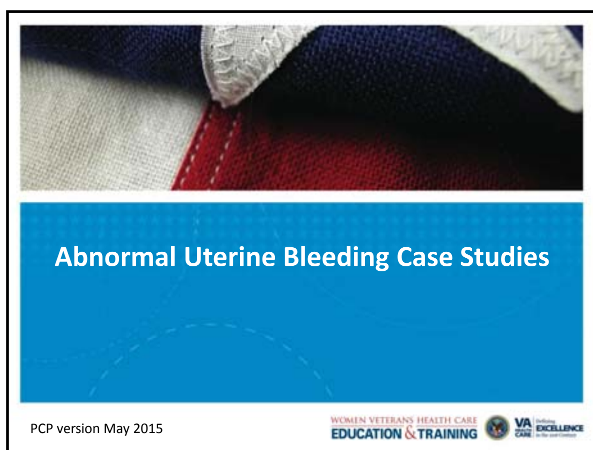
"My pain continues to be unbearable. None of the medications you have given me are helping. I took some Percocet from my friend and this really helped. Can you please order some for me? I can pick it up tomorrow."

Table Discussion

How would you handle this request?

Strategies for Managing the Challenging Patient

- Keep her perspective and experience in mind
- Distinguish your personal issues from hers
- Employ your motivational interviewing techniques
- Get a second opinion or discuss her case with a colleague
- Use a multidisciplinary approach: GYN, pain clinic, MH, and SW
- Monitor yourself for burnout
- Schedule regular follow-ups
  - Patient feels cared for and understood
  - Addresses small concerns before they become overwhelming
- Educate on appropriate use of phone/email as alternatives to more frequent visits



Abnormal Uterine Bleeding Case Studies

PCP version May 2015

WOMEN VETERANS HEALTH CARE EDUCATION & TRAINING

Case Study 1

Yvonne, a 24-year-old married female, calls the clinic first thing in the morning with a complaint of heavy vaginal bleeding.

"I bled through my tampon and pad again, and my nightgown and bedding are soiled. I'm sick of this – I just want it to stop!"

Q1: What is the most important information for your triage nurse to obtain at this point?

Q1: What is the most important information for your triage nurse to obtain at this point?

- Acute vs. Chronic
  - Has this happened before?
- Stable vs. Unstable
  - Is she lightheaded? Short of breath?
- Pregnancy Status
  - LMP? Contraception?
- Systemic Symptoms
  - Abdominal pain? Pelvic pain? Urinary symptoms?

Case Study 1 (continued)

Yvonne tells the nurse that her periods have gradually gotten worse. They are now lasting 6-7 days instead of 3-4, and come every 30 days instead of every 26. The flow on her first few days has also gotten much heavier. She has no pain, cramping, or vaginal discharge. She has never missed a menstrual cycle. She has not been sexually active for a month.

Your triage nurse offers Yvonne an open slot later that morning and she agrees to come in.

Case Study 1 (continued)

Yvonne arrives early as instructed to have a urine HCG completed prior to seeing you. The test is negative. The exam room is set up for a pelvic exam.

You note that her medical history is remarkable only for severe reflux disease for which she takes daily Prilosec. She smokes occasionally when out with friends.

Vital signs: T 98.4, HR 80, RR 16, BP 130/86; 5'3", 210 lbs., BMI 37.2, pain 0/10

Table Discussion

Do you have point-of-care (POC) urine HCG available at your facility?

Who initiates the testing?

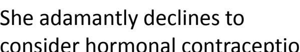
Would you have ordered it in advance?

Discussion Points: Other Lab Tests to Consider

- Check hemoglobin/hematocrit for anemia and ferritin for iron deficiency
- Hypothyroidism presents with heavy menses and should always be ruled out
- Von Willebrand disease is the most common coagulation disorder causing menorrhagia, but it is not usually checked unless there are other signs of bleeding or the patient is an adolescent

Case Study 1 (continued)

All of Yvonne's laboratory test results are normal. She reports missing 1-2 days of work per month and she is avoiding social activities during the first three days of her period.



She adamantly declines to consider hormonal contraception.

Q2: The best alternative strategy for managing her cycles includes which of these?

A. Reassurance

B. Iron supplementation

C. Acetaminophen during her menstrual cycles

D. Daily ibuprofen from the beginning of her menstrual cycle through the end of her menses

Q2: The best alternative strategy for managing her cycles includes which of these?

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Discussion Points

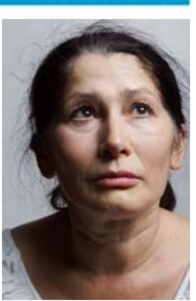
- The appropriate management depends on the patient's medical history, risks, and personal choices
- If contraception is desired, either combination contraception or Mirena® IUD/IUS would be indicated
  - If she is unwilling or unable to take estrogen (i.e., clotting risk), a progesterone-only contraception is appropriate
- If she does not desire contraception, or doesn't want to take any hormones, NSAIDs alone may be enough

What to do if Yvonne's pregnancy test had been positive…

- Significant bleeding in early pregnancy warrants emergency evaluation to rule out:
  - Ectopic pregnancy
  - Spontaneous, threatening, or impending abortion
- Identify your point of contact for urgent obstetric problems at your local facility

Case Study 2

Olivia, a 51-year-old female, presents for an appointment with her PCP. During intake, she complains of heavy menstrual bleeding. She reports 6 weeks of "bleeding all the time". She cannot be more specific about her bleeding pattern. She is fatigued. On further questioning, she endorses increased sweating, palpitations, and insomnia.



Q3: What additional information would you want? Does she need a pregnancy test?

Q3: What additional information would you want? Does she need a pregnancy test?

- Pregnancy status
  - Any woman with a history of abnormal menses should have a urine pregnancy test!
- Hypotension, tachycardia, orthostasis
- Fever, ill appearance
- Abdominal/pelvic pain
- Menstruation pattern
- Estimated blood loss

Note… FSH/estradiol levels not useful in perimenopause

Case Study 2 (continued)

Olivia's pregnancy test is negative. Further history suggests that she is perimenopausal. Her blood work shows a normal TSH and a low ferritin level.

Olivia has a history of fibroids, polycystic ovarian syndrome with anovulatory cycles, and long-term oral contraceptive use however she stopped taking her OCPs about 6 months ago. She reports that she has sometimes gone "months without a period" over the past 2 years.

Vital signs: T 98.4, HR 80, RR 15, BP 130/85; 5'3", 205 lbs, BMI 36.3; pain 1/10

Case Study 2 (continued)

Because Olivia has a history of PCOS and anovulatory cycles, the provider decides to order a pelvic (transvaginal) ultrasound, and to refer Olivia to gynecology for an endometrial biopsy.

Table Discussion

In your clinic, how would Olivia get her endometrial biopsy results?

Do you track consults and radiology orders? If so, how? If not, how could it be done?

How would you know if a specimen was lost on the way to the lab and never processed?

Case Study 2 (continued)

Olivia's transvaginal ultrasound and endometrial biopsy test results are normal.

Q4: Appropriate management for Olivia's symptoms of abnormal bleeding in the perimenopausal time period include all EXCEPT:

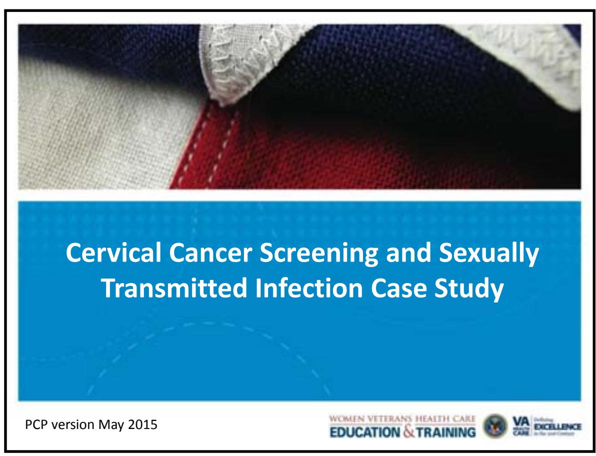
A. Combination hormonal contraception
B. Combination postmenopausal hormone therapy with estradiol and medroxyprogesterone acetate
C. Mirena® IUD/IUS
D. Intermittent medroxyprogesterone acetate

Q4: Appropriate management for Olivia's symptoms of abnormal bleeding in the perimenopausal time period include all EXCEPT:

A. Combination hormonal contraception
B. Combination postmenopausal hormone therapy with estradiol and medroxyprogesterone acetate
C. Mirena® IUD/IUS
D. Intermittent medroxyprogesterone acetate

Discussion Points

- A combined estrogen/progestin contraceptive such as the pill, patch, or ring will provide enough hormone to shut down the ovaries and thus control the bleeding by regulating the cycle
- Hormone therapy for a patient who is intermittently ovulating does not suppress ovarian function; thus, HT may make perimenopausal bleeding worse
- Levonorgestrel (Mirena® IUD/IUS) or intermittent medroxyprogesterone acetate will thin the uterine lining and thus diminish bleeding



Cervical Cancer Screening and Sexually Transmitted Infection Case Study

PCP version May 2015

WOMEN VETERANS HEALTH CARE EDUCATION & TRAINING

Case Study

Joyce, a 32-year-old returning Veteran, comes in for a well-woman visit. She is due for cervical cancer screening. Her previous Paps have been normal. She has no other acute concerns today.

Vital signs: T 97.9 F, HR 75, BP 122/82, RR 17; 5'6", 141 lbs., BMI 22.8, pain 0/10

Q1: Joyce's Pap results come back as ASC-US (atypical squamous cells of undetermined significance). What are some possible next steps?

A. If liquid-based cytology was used, await reflex HPV testing results. If positive, refer to colposcopy.

B. Refer immediately to colposcopy.

C. Repeat Pap test in 12 months.

D. Repeat Pap test in 3 years.

Q1: Joyce's Pap results come back as ASC-US (atypical squamous cells of undetermined significance). What are some possible next steps?

A. If liquid based cytology was used, await reflex HPV testing results. If positive, refer to colposcopy.

B. Refer immediately to colposcopy.

C. Repeat Pap test in 12 months.

D. Repeat Pap test in 3 years.

Discussion Points

- Option A: Reflex testing for HPV (if liquid cytology is used, or if a separate sample is collected at time of the Pap) is preferred for patient convenience and cost-effectiveness
  - Women who test HPV negative: risk of harboring CIN 2/3 is less than 2%; can perform co-testing in 3 years
  - Women who test HPV positive: refer for colposcopy due to 15-27% chance of CIN 2/3+ (unless under the age of 25 where repeat testing in 1 year is suggested)
- Option B: Immediate colposcopy is no longer recommended
- Option C: Recommended if HPV reflex testing is not possible
- Option D: Waiting for routine testing in 3 years would be too long

Table Discussion

What are the Women's Health PACT roles in facilitating cervical cancer screening, tracking and communicating results?

How can all team members play a role?

WH PACT and Cervical Cancer Screening

Possible activities:

- Pap tracking (including abnormal results)
- Identifying patients who are overdue and bringing into clinic
- Discussing abnormal results
- Patient education on current guidelines
- Others?

Q2: What if Joyce's Pap results come back as L-SIL (low-grade squamous intraepithelial lesion)? Co-testing wasn't performed. What is your next step?

A. Repeat Pap smear immediately
B. Repeat Pap smear in 6 months
C. Refer for colposcopy

Q2: What if Joyce's Pap results come back as L-SIL (low-grade squamous intraepithelial lesion)? Co-testing wasn't performed. What is your next step?

A. Repeat Pap smear immediately
B. Repeat Pap smear in 6 months
C. Refer for colposcopy

Q3: What if Joyce *was* co-tested and her HPV came back negative with the LSIL Pap?

Q3: What if Joyce *was* co-tested and her HPV came back negative with the LSIL Pap?

- Repeat Pap with HPV co-testing in one year
- Going straight to colposcopy is also acceptable but not preferred

Q4: Would your management change if Joyce was 23 years old with an LSIL Pap?

Q4: Would your management change if Joyce was 23 years old with an LSIL Pap?

- Repeat Pap test in one year
  - If normal, repeat again one year later. If negative x 2, return to normal screening.
  - If ASC-US or LSIL, repeat in one year. Refer to colposcopy at that point if still abnormal.
  - If ASC-H, HSIL, or ACG, refer to colposcopy

Discussion Points

- Data shows the natural history of LSIL approximates that of HPV+ ASC-US
- LSIL without known HPV status is treated as if HPV+ and goes directly for colposcopy
- Most younger women (<24) with LSIL will return to normal on their own

Q5: What if her Pap comes back with… "No evidence of malignancy. No endocervical cells"?

Discussion Points

- Current guidelines do NOT recommend repeating the Pap test if endocervical cells were not present as long as the cervix was adequately visualized on exam
- This is not the same as an "unsatisfactory" finding
- Older women are more likely to have the "no EC" finding and are at lower CIN3+ risk

Q6. Six months later, Joyce presents with complaints of vaginal discharge, burning and itching. How would you like to see this issue triaged?

Q4. Six months later, Joyce presents with complaints of vaginal discharge, burning, and itching. How would you like to see this issue triaged?

Additional History needed:

- LMP
- Change in color, volume, or odor of discharge
- Irritative symptoms: itching, burning
- Urinary frequency or urgency, or painful urination
- Intermenstrual or post-coital spotting
- Acute lower abdominal/pelvic pain or low back pain
- Pain during intercourse
- Fever, chills
- Nausea or vomiting

Case Study (continued)

Joyce comes in for an appointment that afternoon.

In response to sexual history queries, she reports a new sexual partner and inconsistent condom use.

Q5. What are the next diagnostic steps?

A. Vaginal pH
B. Amine (whiff test)
C. Potassium hydroxide (KOH) microscopy
D. Normal saline microscopy
E. BD Affirm™ point-of-care testing
F. All of the above

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A. Vaginal pH
B. Amine (whiff test)
C. Potassium hydroxide (KOH) microscopy
D. Normal saline microscopy
E. BD Affirm™ point-of-care testing
F. All of the above (if available)

Discussion

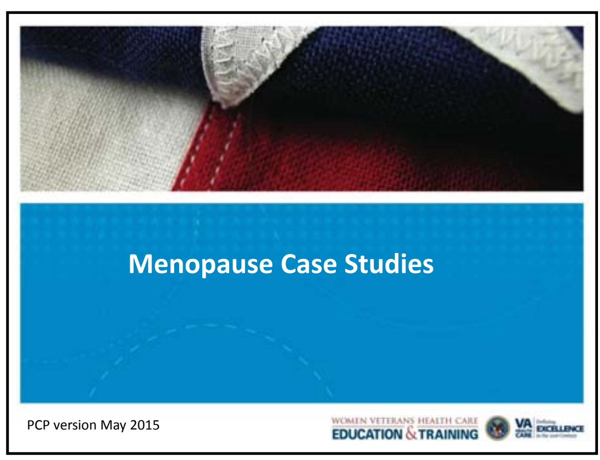
- Obtain specimens from lateral vaginal wall for laboratory evaluation. Evaluations should include vaginal pH, amine (whiff) test, saline and 10% potassium hydroxide (KOH) microscopy.
- Normal pH (< 4.5) rules out bacterial vaginosis, whereas pH > 4.5 has a limited differential diagnosis.
- Perform whiff test for amines by placing a drop of 10% KOH on vaginal secretions and checking for a fishy odor.
- Saline microscopy can identify trichomonads and clue cells.
- KOH microscopy can identify pseudohyphae and yeast buds.
- BD Affirm™ can identify candida species, trichomonas vaginalis, and gardnerella vaginalis. Turnaround time may vary by facility.

Case Study (continued)

Joyce's exam reveals a frothy, yellow-green discharge with erythematous punctuate lesions on the cervix. A whiff test is negative and pH is 5. Trichomonads are seen on the wet mount.

Table Discussion

- When and how do you counsel your patients on STI risk, screening, and treatment?
- Who do your patients ask about STI risk?
- What are some approaches your PACT can use to inform and encourage STI awareness and screening?



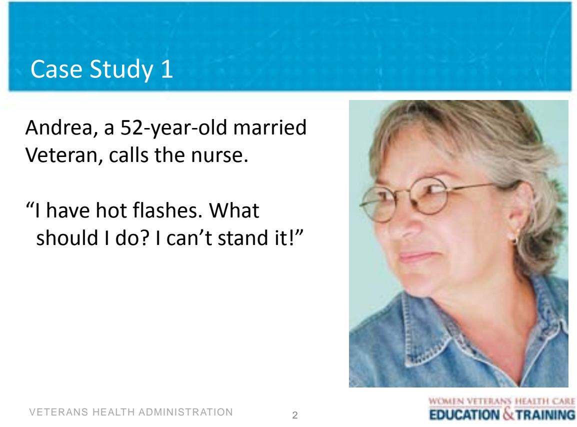
Menopause Case Studies

PCP version May 2015

Case Study 1

Andrea, a 52-year-old married Veteran, calls the nurse.

"I have hot flashes. What should I do? I can't stand it!"



Q1: What questions would you like the nurse to ask during phone triage?

Q1: Q1: What questions would you like the nurse to ask during phone triage?

- Hot flashes new or ongoing?
- Frequency and duration of the flashes?
- Chest pain or shortness of breath along with flashes?

As part of triage, we need to consider causes other than menopause for the hot flashes.

Case Study 1 (continued)

Andrea is scheduled for an appointment in two weeks so that she and her provider can talk about what is best for her.

Table Discussion

Because there is a 2-week wait for an appointment, what advice could your nurse give Andrea about symptom management until she sees you?

Discussion Points

Conservative measures for symptom control:

- Dress in layers
- Use small, portable fans
- Avoid spicy foods, caffeine, chocolate, and alcohol (especially red wine)
  - A food diary might highlight specific foods that trigger vasomotor symptoms
- Yoga and relaxation
- Smoking cessation

Case Study 1 (continued)

Andrea arrives at the clinic for her appointment. She's tried many of the suggested strategies and nothing seems to work.

She notes that she is most concerned about hot flashes. For the last year, she has been experiencing 6-7 per day and often wakes up at night drenched in sweat. She feels fatigued and irritable most of the time. She has not had her menses for the last year, and reports significant vaginal dryness.

Case Study 1 (continued)

Andrea is a non-smoker and her only medical problem is hypertension, which is well controlled with hydrochlorothiazide. She has never had an abnormal mammogram, breast biopsy, or gynecologic surgery. Her mother had a heart attack at age 65, and Andrea is worried about having one herself.

She has heard concerning things about hormone replacement therapy and the risk of MI. She wonders if her risk will significantly increase if she starts HRT now.

Q2. What do you tell Andrea about her risk for MI with combination E+P therapy?

A. She should avoid combination E+P therapy because it will substantially increase her risk for MI

B. E+P therapy will increase her risk for MI now, but if she waits until she is 62 she can safely start it

C. She could wait to start E+P therapy until she is later in menopause, because it seems to be safer then

D. She should start E+P therapy now, as her baseline risk for MI is low

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D. She should start E+P therapy now, as her baseline risk for MI is low

Discussion Points

- Based on reanalysis of WHI data, as well as HERS data, the risk for MI is not increased in early menopause (<10 years)
- Risk for MI with E+P was primarily noted in older women, who were much more distant from the onset of menopause

Case Study 1 (continued)

After discussing the pros and cons of HRT with you, Andrea is very eager to start it. Based on the information you provided, she knows HRT comes as a patch, pill, a vaginal ring, and vaginal cream. She wonders which is best for her.

Q3. Which of the following is true?

A. Oral HRT is more effective than vaginal or transdermal methods for relieving vasomotor symptoms

B. Transdermal hormone therapy is less likely to be associated with stroke and DVT than oral therapy

C. As compared to low dose HRT, higher doses of HRT are more effective for relieving hot flushes and just as safe

D. Once started, women should stay on HRT for at least 10 years to avoid the recurrence of any hot flushes

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C. As compared to low dose HRT, higher doses of HRT are more effective for relieving hot flushes and just as safe

D. Once started, women should stay on HRT for at least 10 years to avoid the recurrence of any hot flushes

Discussion Points

- All routes of systemic therapy are equally effective
- Transdermal route is associated with decreased risk of stroke and VTE vs. oral route
- Use lowest effective dose to relieve symptoms: 0.625 mg per day or lower
- Continuous regimens are associated with fewer hot flushes during estrogen-free periods and eventually induce amenorrhea in most women
- Vaginal estrogen primarily has local effects only (exceptions are Femring or using topical estrogen >2x/week which achieves systemic levels). Because they act locally, will improve vaginal symptoms, but will avoid systemic risks.

Case Study 2

Marion, a 53-year-old Veteran, comes to your clinic. She is a current smoker with a strong family history of breast cancer. She presents with complaints of "always being angry these days".

She is unhappy because she and her husband used to have a healthy sex life, but it has been nonexistent for many months. Her performance at work is also suffering. Friends and co-workers comment on her frequent hot flushes, red face, and sweating. Marion is taking black cohosh OTC.

Table Discussion

What types of bothersome symptoms does she report?

What is the best way to address these as a team?

Discussion Points

What types of bothersome symptoms does she report?

- Anger
- Loss of sexual intimacy
- Vasomotor symptoms

Options for addressing:

- Treat vasomotor symptoms
- Treat possible vaginal atrophy or dryness
- Consider PCMHI or Mental Health referral

Name: ____________________________ **ACTION PLAN** Facility: _____________________________

Date: ______________________________ Circle one: Med Center CBOC

A. Idea: What issues have you have identified that you want to address?

B. Who should be on our team?

	Stakeholder group (e.g. provider, nurse manager, lab)	*Individual's name/title (note: indicate team leader with '*')*
1		
2		
3		
4		
5		
6		

C. What are we trying to accomplish? Name 1-2 aims that are time-specific and measurable. (Note: this is typically done by the team, but try to define this now as part of the exercise; the whole team must agree on the aim)

	Aim	What overarching clinical care aims does this support? (Safety, effectiveness, efficiency, equity, patient-centeredness, timeliness)?
1		
2		

D. How will we know that a change is an improvement? List specific, measurable, realistic, time-specific elements you will follow over time to see if the plan is successful.

	Measure	*Goal for measure*
1		
2		
3		

E. Perhaps there is more than one path to achieve the ultimate aims. List a few possible ways to achieve your goals.

Option:

1

2

3

4

F. What are steps to achieve the change? Select the change from above that you think will be most successful and list the possible steps it will take to achieve the goal. (Note: the group will ultimately decide on the best change to address)

	Step	*Who is responsible? By when?*
1		
2		
3		
4		
5		
6		

Action Plan Template

Name: ______________________ ACTION PLAN Facility: ____________________

Date: ______________________ Circle one: Med Center CBOC

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	Stakeholder group (e.g. provider, nurse manager, lab)	*Individual's name/title (note: indicate team leader with '*')*
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	Aim	What overarching clinical care aims does this support? (Safety, effectiveness, efficiency, equity, patient-centeredness, timeliness?)
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	Step	*Who is responsible? By when?*
1		
2		
3		

Example #1

Name: ____________________

ACTION PLAN TEMPLATE

SAMPLE 1

Facility: ____________________

Circle one: Med Center CBOC

Idea: What issue have you identified that you want to address?

When a patient comes in with vaginitis, we have no microscope on site, so we treat the patient with multiple empiric antibiotics and never get a diagnosis

Who should be on our team?

	Stakeholder group (e.g., provider, nurse manager, lab)	*Individual's name/title (note: indicate team leader with '*')*
1	Provider	LV
2	Nurse Manager (clinic budget)	AAA
3	Chief Physician (medical expertise)	BBB
4	Lab	CCC
5	SPD	DDD
6		

What are we trying to accomplish? Name 1-2 aims that are time-specific and measurable. (Note: this is typically done by the team, but try to define this now as part of the exercise; the whole team must agree on the aim)

	Aim	*What overarching clinical care aims does this support? (safety, effectiveness, efficiency, equity, patient-centeredness, timeliness)?*
1	Be able to diagnose cause of vaginitis within the next 3 months	Efficiency, timeliness
2	Decrease use of empiric antibiotics	

How will we know that a change is an improvement? List specific, measurable, realistic, time-specific elements you will follow over time to see if the plan is successful.

	Measure	*Goal for measure*
1	Testing available at our site	Within 3 months
2	decrease in use of a multi-drug empiric regimen for vaginitis	50% reduction in 6 months; 80% reduction in one year
3		

What changes can we make that will result in an improvement? List a few possible ways/paths to achieve your goals.

Option:

1 purchase microscope (need a way to maintain, ensure proficiency, meet Joint Commission lab standards, etc.)

2 purchase vaginitis testing (need to check vendors, work with lab for testing, etc.)

3

Example #2

Name: ______________________________

ACTION PLAN TEMPLATE

SAMPLE 2

Facility: ______________________________

Circle one: Med Center CBOC

Idea: What issue have you identified that you want to address?

There is only one PCP at a CBOC who cares for women patients. There is no one to provide comprehensive primary care to women if this provider goes on prolonged leave or leaves/changes clinics, etc.

Who should be on our team?

	Stakeholder group (e.g., provider, nurse manager, lab)	*Individual's name/title (note: indicate team leader with '*')*
1	PCP	LV
2	Women Veteran Program Manager	AAA
3	Chief, Primary Care (scheduling, hiring, etc)	BBB
4	CBOC Nurse Manager (scheduling, hiring)	CCC
5	Facility Education Department	DDD
6		

What are we trying to accomplish? Name 1-2 aims that are time-specific and measurable. (Note: this is typically done by the team, but try to define this now as part of the exercise; the whole team must agree on the aim)

	Aim	*What overarching clinical care aims does this support? (safety, effectiveness, efficiency, equity, patient-centeredness, timeliness)?*
1	At least one additional Women's health PCP available at that CBOC	Equity, patient-centeredness, timeliness
2	All Women's Health PCPs who care for women patients have enough patients and training to remain competent	SAME

How will we know that a change is an improvement? List specific, measurable, realistic, time-specific elements you will follow over time to see if the plan is successful.

	Measure	*Goal for measure*
1	Number of designated women's health comprehensive primary care providers	minimum of 2 within 6 moths
2	Number of women seen by a designated women's health comprehensive primary care provider	80% in 6 months
3	Number of providers trained or hired	at least one in 6 months

What changes can we make that will result in an improvement? List a few possible ways/paths to achieve your goals.

Option:

1 train one provider currently in the CBOC

2 Hire a proficient WH provider

Helpful Resources

Literature Cited in the Lectures

Contraception Lecture

Helpful Resources

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Interpersonal Violence Lecture

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http://cc.cityandcountry.org/upanddown/ups/VEHU%20Interpersonal%20Violence/Resources:%20IPV/IPV%20Reproductive-Health-Guidelines.pdf

- CDC. *Intimate partner violence.* [Information, publications, resources] http://www.cdc.gov/ViolencePrevention/intimatepartnerviolence/index.html
- Domesticshelters.org. [Find local domestic violence help and closest shelter.] https://www.domesticshelters.org/
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- Futures Without Violence. [Programs, policies, campaigns, information on violence against women and children] http://www.futureswithoutviolence.org/about-us/our-mission/
- Futures Without Violence*. Mandatory Reporting of Domestic Violence to Law Enforcement by Health Care Providers: A Guide for Advocates Working to Respond to or Amend Reporting Laws Related to Domestic Violence, n.d.* http://cc.cityandcountry.org/upanddown/ups/VEHU%20Interpersonal%20Violence/Resources:%20IPV/Mandatory_Reporting_of_DV_to_Law-Enforcement_by_HCP.pdf
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- Johns Hopkins School of Nursing. *The Danger Assessment, 2015*. [Assessment training] http://www.dangerassessment.org/
- National Center for PTSD. *Intimate Partner Violence.*[Information and resources specific to Veterans and families] http://www.ptsd.va.gov/public/types/violence/domestic-violence.asp
- National Coalition Against Domestic Violence. [Information on DV statistics, reproductive coercion, HIV/AIDS and DV, cosmetic and reconstructive support, financial education, and influencing public policy. National registry of names of those who have lost their lives due to violence. Help finding local shelters] http://www.ncadv.org/
- National Coalition Against Domestic Violence [Safety plan] http://www.ncadv.org/need-support/get-help
- National Dating Abuse Helpline [Information on dating basics, recognizing abuse, getting help, taking action, and hotline: 866-331-9474 or TTY 866-331-8453 or text "loveis" to 22522. Live chat is also available.] www.loveisrespect.org
- National Domestic Violence Hotline. *Safety Planning with Children.* [How to develop a safety plan] http://www.thehotline.org/2013/04/safety-planning-with-children/
- National Domestic Violence Hotline [Information, resources, and toll-free, 24-hour hotline: 1-800-799-SAFE (7233) or TTY 1-800-787-3224. Live chat is also available.] http://www.ndvh.org
- Rape, Abuse & Incest National Network [News, programs, and hotline: 1-800-656-HOPE (4673)] http://www.rainn.org

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Pelvic Exam and Cervical Cancer Screening Lecture

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Menopause Lecture

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