

Clinicians' FORUM

From time to time, the editors of *Menopause Management* field interesting clinical questions and dilemmas. In this forum, our Editorial Advisory Board members, experts in a range of fields related to midlife women's health, tell readers how they handle these situations.

The viewpoints expressed in "Clinicians' Forum" are those of the contributors, and not necessarily those of *Menopause Management* or The North American Menopause Society (NAMS).

Question: We are all aware that every patient interaction should ideally involve a preventive health-care component beyond addressing the complaint of immediate concern. What, in your clinical practice, do you find to be the impediments to this approach, both clinical- and insurance-related? Do you have any suggestions or pearls of wisdom to offer as solutions?

Answers:

Perhaps we are approaching the issue of adding a preventive health component to the annual examination in the wrong way. Rather, we should be speaking of how to add the pelvic examination to the preventive health interventions that we offer our patients during each annual gynecologic evaluation. That is, let's devote the annual well-woman visit to addressing preventive health issues and skip the pelvic examination in asymptomatic women who do not have genital complaints. There are data suggesting that pelvic examination in asymptomatic women rarely leads to

significant findings that influence management of those patients.¹ The pelvic examination should be reserved for women who have genital complaints or who need a Pap smear, vaginal smear, colposcopy or a surgical intervention such as a vulvar or endometrial biopsy. For most practitioners, comfortably assisting the woman, especially the older woman, into the dorso-lithotomy position, then performing the speculum evaluation, followed by the bimanual examination and, finally, assisting the patient into the upright position again usually consumes a substantial portion of the physician-patient interaction time.

The yield of the pelvic examination is limited, and accuracy diminishes in patients with a large body habitus, in those with high levels of anxiety, and in women who tense their abdominal muscles in response to pain elicited during the speculum insertion and during palpation of the abdomen and pelvis. In one study,² the ability to diagnose adnexal pathology by bimanual evaluation was, in most instances, no greater than by chance. Data reported by Padilla and colleagues suggested that the most accurate bimanual examinations are performed by postgraduate residents when they are evaluating the left adnexa.² In this

Participants

Gloria Bachmann, MD
Associate Dean for Women's Health
Professor of Ob/Gyn & Medicine
UMDNJ-Robert Wood Johnson Medical School
New Brunswick, NJ

JoAnn V. Pinkerton, MD
Director, Midlife Health
Professor of Ob/Gyn
University of Virginia Health System
Charlottesville, VA

Holly L. Thacker, MD, FACP, CCD
Director, Women's Health Center
Associate Professor of Surgery
Cleveland Clinic Lerner College of Medicine of CWRU
Cleveland, OH

Robert Wild, MD, PhD, MPH
Professor of Reproductive Endocrinology, Gynecology,
Medicine, and Clinical Epidemiology
Oklahoma University Health Sciences Center
Oklahoma City, OK

study, postgraduate residents lost significant accuracy when they were evaluating the right adnexa.² As well, accuracy of the pelvic examination diminished further when the patient was obese.³ Because of these hurdles in accurately assessing internal genitalia, perhaps clinical decisions should not be based solely on the findings noted on pelvic examination. Techniques widely available for evaluating possible pelvic pathology—such as transabdominal and transvaginal pelvic ultrasound—have greater accuracy, positive predictive value and test efficiency than the bimanual pelvic examination.



Gloria Bachmann, MD

ating possible pelvic pathology—such as transabdominal and transvaginal pelvic ultrasound—have greater accuracy, positive predictive value and test efficiency than the bimanual pelvic examination.

To set the record straight, I am not suggesting elimination of the pelvic examination in women who are at high risk, or in those who have symptoms/complaints that may be related to gynecologic pathology or who do not meet the criteria for less frequent screening as set forth by the professional societies. Rather, let's forgo the pelvic examination in asymptomatic women who meet the American College of Obstetricians and Gynecologists guidelines stating that low-risk women over the age of 19 who have had three consecutive normal Pap tests do not need annual cervical cytology evaluations. Many perimenopausal and menopausal women definitely fit into this category. Devoting time to preventive health strategies in this cohort may be of greater benefit to these women during their annual well-woman visits than having a routine pelvic examination.

—Gloria Bachmann, MD

References

1. Singh RH, Erbelding EJ, Zenilman JM, et al. The role of speculum and bimanual examinations when evaluating STD clinic attendees. *Sex Transm Infect* 2007;83:206-10. Epub 2006, Nov 15.
2. Padilla LA, Radosevich DM, Milad MP. Accuracy of the pelvic examination in detecting adnexal masses. *Obstet Gynecol* 2000;96:593-98.
3. Padilla LA, Radosevich DM, Milad MP. Limitations of the pelvic examination for evaluation of the female pelvic organs. *Int J Gynecol Obstet* 2005;88:84-88.

Clinical preventive services delivered in a physician's office or clinic for women include counseling individuals to maintain healthy lifestyles and avoid unhealthful behaviors, immunizing to prevent future disease, and screening individuals to identify diseases that are present but not yet symptomatic. Most clinical preventive services are cost-effective, and certain preventive services actually save more money than they cost because counseling, education and screening promote healthy behaviors that prevent or minimize the occurrence of many serious health conditions. A menopause practice lends itself to offering preventive health care because women in midlife are frequently in times of transition. They are so busy being caregivers for children, elderly parents or both, that they may have forgotten to take care of themselves.

Beyond the traditional history and physical, mammograms and Pap smears are two preventive services that are especially important to women's health. The US Preventive Services Task Force recommends that Pap smears to screen for cervical cancer begin within 3 years from the initiation of sexual activity, or at age 21 (which ever comes first).

The Task Force further recommends mammography every 1-2 years in women age 40 and older. Hearing and vision exams are recommended for those 65 and older. Additional preventive screenings for women between the ages of 25 and 64 include:

- Blood pressure
- Height, weight and body mass index
- Assessment for cigarette smoking, drug use and problem drinking
- Depression screening
- Screening for domestic violence or intimate physical violence
- Screening for sexually transmitted diseases (STDs), as indicated
- Bone density, depending on risk factors
- Lipid profile if 45 or older, or with risk



JoAnn V. Pinkerton, MD

factors such as cigarette smoking, diabetes, family history of heart disease, hypercholesterolemia or heart disease.

- Colon cancer screening, initiated at age 50 and performed periodically thereafter unless family history indicates the need for earlier/more frequent screening
- Counseling and education, which may center on specific areas such as weight gain or lack of exercise. Specific recommendations may include:
 - Encouraging weight loss of 10% if overweight, emphasizing grains, fruits and vegetables
 - Encouraging adequate calcium and vitamin D intake
- Stressing the need for regular exercise, both aerobic (30 minutes, 5 days per week) and strength-training
- Offering assistance with smoking cessation, including development of a plan, use of prescription aids when indicated, etc.
- Inquiring about the use of devices for injury prevention (seat belts, helmets, smoke detectors) and condoms for STD protection
- Offering pertinent immunizations, including influenza (annually), pneumonia vaccine for those over 65, and tetanus and diphtheria every 10 years
- Possible recommendation of aspirin therapy for postmenopausal women at risk for cardiac disease (if not contraindicated).

“Priorities for America’s Health: Capitalizing on Life-Saving, Cost-Effective Preventive Services,”¹ a report by the Partnership for Prevention, sheds light on the startling fact that more than 50% of Americans who need valuable preventive services do not receive them. In fact, less than half of the people who need them actually avail themselves of what are deemed five of the most cost-effective preventive services, perhaps because some clinicians may be failing to incorporate discussion of these services (listed below) into routine counseling and education:

1. Discussion of daily aspirin use with at-risk adults (when not contraindicated)
2. Screening adults age 50+ for colorectal cancer

3. Intervening with smokers by offering therapies or referrals to help them quit
4. Offering a pneumonia vaccine for women 65 and older
5. Screening young, sexually active women for Chlamydia which, if treated, would decrease infertility.

Maciosek and colleagues² have summed up my thoughts on preventive health: “If these services were more consistently offered to the American people, fewer people would die and fewer people would suffer from diseases that are preventable. The U.S. could also get more for the dollars it invests in health care by focusing on the services that provide the most benefits at the least cost, while also making progress toward reducing disparities in health outcomes.”

—*JoAnn V. Pinkerton, MD*

References

1. Partners for Prevention. *Priorities for America’s health. Capitalizing on life-saving, cost-effective preventive services.* Washington, DC. Available at www.prevent.org/ncpp.
2. Maciosek MV, Coffield AB, Edwards NM, et al. Priorities among effective clinical preventive services: results of a systematic review and analysis. *Am J Prev Med* 2006;31:52-61.

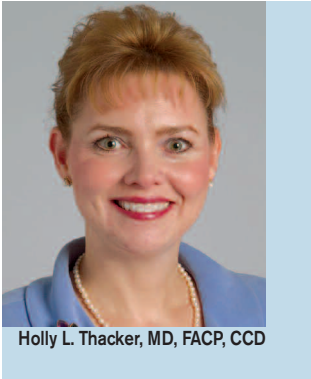
Resources

Medicare preventive health codes:

- Pneumonia vaccination: 90732 plus G0009 for administration
- Influenza vaccination: 90658 plus G0008 for administration
- Smoking cessation counseling: 3-10 minutes, G0375, >10 minutes, G0376
- Welcome to Medicare exam: once within 6 months of enrollment, G03444 (must do EKG using separate code)

A menopause practice should, by definition, weave preventive health maintenance (HM) into problem-based office care. Midlife is an optimal time to reassess health habits and update HM. Time constraints and lack of universal insurance coverage for routine preventive care are impediments. I employ several strategies to address time constraints: I educate my office staff on HM guidelines¹ so that they can inquire and/or offer preventive services for women scheduling appointments. Protocols regarding routine immunizations—including fall flu vaccinations, standing yearly orders for screening mammography, and a call-back system for abnormal bone

densities²—help to facilitate care. I utilize “shared medical appointments”³ for both follow-up and annual visits of existing patients. This format lends itself to preventive care that includes time to counsel on such important areas as weight management, exercise, smoking cessation, risks/benefits of hormone therapy (HT) as well as alternatives to HT, the need for calcium and vitamin D₃ supplementation in most women, as well as offering newer vaccinations such as Tdap (tetanus, diphtheria, acellular pertussis) and Zostavax (shingles vaccine).



Holly L. Thacker, MD, FACP, CCD

I give all new patients copies of a standard living will/durable power of attorney in a pink folder. Also included is the following critical health information:

I give all new patients copies of a standard living will/durable power of attorney in a pink folder. Also included is the following critical health information:

- HM guidelines, referral phone numbers for intimate partner violence, and safety information (including the need for seat belt usage)
- Recommended labs, including a fasting lipid profile every 5 years, fasting blood glucose every 3 years beginning at age 45 (or younger, if indicated) and periodic labs such as thyroid-stimulating hormone (TSH) and HIV testing
- Information about the need for periodic eye and dental exams
- Important health Web sites such as that for The North American Menopause Society (www.menopause.org).

I expect women in my practice to follow and track their numbers—body mass index, blood pressure and lipid ratios—and to keep their own health files. Many insurance policies will not cover routine screening lipids and TSH blood tests, but will cover these tests if the woman has had abnormal weight gain (ICD code 783.1).

When seeing patients, I think in terms of decades:

- Age 30: start offering human papilloma

virus DNA testing along with the Pap smear every 3 years

- Age 40: begin yearly mammography
- Age 50: begin periodic colon cancer screening.
- Age 60-65: obtain bone density if not done earlier, offer pneumococcal vaccination, and discuss use of preventive baby aspirin for stroke risk reduction

When examining women, I note any abrasions (ICD code 919.0), such as on the lower legs from shaving, as an indication for a tetanus booster if it has been more than 10 years since immunization. Colonoscopy is one of the more expensive screening tests. Many insurance companies will not cover screening colonoscopy; however, they will usually cover diagnostic colonoscopy. When treating a perimenopausal women with menorrhagia from fibroids with resultant iron-deficiency anemia, I always take the opportunity to also recommend complete bowel examination with diagnostic colonoscopy to exclude any colonic source of blood loss, rather than assuming that the anemia is due solely to menstrual losses.

I have noticed quite a “disconnect” between what women request for screening and what they need.⁴ Many women ask for the “blood test for ovarian cancer,” meaning a

I expect women in my practice to follow and track their numbers—body mass index, blood pressure and lipid ratios—and to keep their own health files.

—Holly L. Thacker, MD, FACP, CCD

CA-125 test, which is not a screening test for ovarian cancer. I take the opportunity to inform them of the subtle symptoms that would prompt an evaluation for ovarian cancer. If there are any symptoms suggestive of pelvic/abdominal fullness and/or discomfort, early satiety, and/or change in bowel habits, I always take this as an opportunity to order a diag-

nostic colonoscopy (in addition to physical examination and pelvic ultrasound) if this has not been done already.

Educating and empowering both the female patient and your office staff, as well as directing your patients to reliable and engaging health information, helps in overcoming the obstacles to weaving preventive health care into a busy office practice caring for women in midlife and beyond.

—Holly L. Thacker, MD, FACP, CCD

References

1. American College of Obstetricians and Gynecologists. Clinical updates in women's health care. Primary and preventive care. April 2007. Available at www.clinicalupdates.org.
2. Shoemaker L, Sikon A, Jain A, et al. Repeat dual-energy x-ray absorptiometry (DXA) resulting from reminder letters for women with a baseline abnormal DXA. *J Clin Densitom* 2007;10:21-24.
3. Thacker HL. The role of shared medical appointments for midlife women. *Menopause Management* 2006;15:18-23, 40.
4. Thacker HL. *Women's health: your body, your hormones, your choices*. Cleveland Clinic Guide. Cleveland, OH: Cleveland Clinic Press, May 2007.

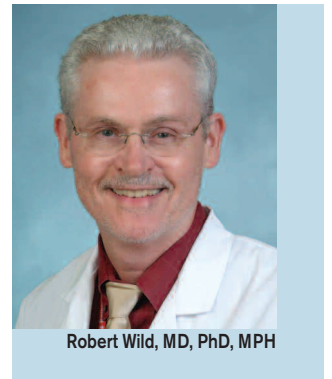
While we focus on specific complaints when our patients come to us for menopause concerns, the practice of prevention requires a number of steps, not all of which are under physician control. Specifics will vary by office delivery system. Barriers include office delivery systems themselves, apathy on the part of patients, providers and/or healthcare decisionmakers, lack of communication, and a national healthcare system that favors reimbursement for overt disease.

Despite these issues, there are a number of components that I have found helpful.

- The first step is to learn and implement evidence-based guidelines from quality sources; in particular, guidelines put forth by the American Heart Association ("Adult Treatment Panel III"), The North American Menopause Society, the American Diabetes Association, and the National Heart, Lung and Blood Institute are very practical and useful.
- The second step is to identify a patient advocate in the office to help deliver or prompt care. Teach this person to work with you, and to educate as an extension of

your prevention management. Teach him or her to use approaches and materials that are culturally specific.

- For each patient encounter, make use of the waiting room (be sure it is functional for very obese persons [eg, chairs without arms, plenty of room between seats, etc]) to screen new patients for the most common issues, including all lifestyle-related issues and depression. Furnishing a clipboard and pencil is very useful, and having a checklist for obesity issues is ideal. The nurse can take vital signs, and can also include measurement of the waist. This is done with the patient in an erect position, with the measurement taken just above the iliac crest while standing and at exhalation. The nurse records this number with the blood pressure and the resting pulse as well as the height, weight and body mass index. A stamp is placed on the chart, providing an opportunity for the nurse to flag any abnormal values. The nurse is responsible for filling out this box for every new and returning patient. This provides an opportunity for you to look at this box as you address any given specific complaint. The nurse checks and inserts any abnormal lab values on a separate piece of paper in the front of the chart prior to your entering the room for the patient encounter.
- Use every patient encounter to prompt preventive care. Every abnormal lab (including any parameter in the fasting lipid profile, diabetes and blood pressure checks) should be followed up via information mailed by your nurse advocate based on access to national guideline information. Remind patients of appointments and follow up on all missed appointments.
- Develop a standardized treatment plan to structure care. Develop your algorithms ahead of time, and keep in mind that many physicians work more effectively with the



Robert Wild, MD, PhD, MPH

help of a flow chart. Use feedback from past performance to foster change in future care.

- Stress the importance of “waist management.” The majority of the risk factors requiring reduction are driven by problems of “waist management,” and waist management, rather than weight loss, is my goal. Emphasize to the patient that you understand she is trying to lose weight, and that what you are trying to do is provide her with a skill set. Most important, you have to practice what you preach. For example, show your patient the pedometer you use to keep track of your daily physical activity. Share anecdotes of food choices, etc. Provide a realistic goal (e.g., losing 10% of current weight is realistic). Most often, patients are unrealistic with respect to their weight-loss expectations, and physicians are unrealistic regarding those expectations for their patients. Emphasize that central fat is the easiest to take off. On a prescription pad, provide the basics of food choice, what to read on labels, and blood pressure and cholesterol goals. Provide practical tips for exercise (30 minutes/day of brisk walking or equivalent for maintenance, or 60 minutes of brisk walking or equivalent for weight loss). Recommend five to nine servings of fruits and vegetables daily, and teach patients about adequate insoluble fiber intake as well as the importance of eating two servings of fish per week.
- Use the depression screening tool, explaining that it is not diagnostic but merely suggests depression (without specifying a cause).
- Further discussion can put the patient at ease with a treatment plan, and may avert the need for referral to a psychiatrist.

Additional Advice

Once the encounter is completed, use electronic calculators for a Framingham score, Gail model or other risk calculators easily accessed on the Web. Follow-up is needed for any abnormal lipid parameter and/or waist circumference. The more abnormal the values, the more frequent the return visits that are required. Nurse-only visits can be billed

for blood pressure and weight checks. A prepared book of useful Web sites provides patients with valuable resources. These include finding a dietician (www.eatright.org) or an exercise specialist (www.acsm.org). If diet and exercise are not effective, treat blood pressure, glucose and cholesterol to target goals. Patients need to understand that their blood pressure, glucose, and cholesterol levels are determined by their genetics and their lifestyle issues. We are, however, now aware of the appropriate target levels for these parameters in terms of preventing disease.

If you are uncomfortable treating diabetes, hypertension or an abnormal cholesterol level, refer to a lipid specialist or a diabetes specialist. Most communities now have a practitioner with complex lipid management or complex diabetic management skills. Utilize allied

Most often, patients are unrealistic with respect to their weight-loss expectations, and physicians are unrealistic regarding those expectations for their patients.

—Robert Wild, MD, PhD, MPH

health professionals and reputable collaborative pharmacists as much as you are able. The practice of prevention is reimbursable.

Learn your ICD9 codes. These are driven by Medicare guidelines and are state-dependent. It is easy to search the Web with the ICD9 code using your area code to determine how much is reimbursed for each visit. Limit all new prevention-only visits to 55 minutes or less. For cardiometabolic syndrome patients, 30 minutes is required. All other prevention visits should be under 25 minutes. Nurse-only visits can be less.

—Robert Wild, MD, PhD, MPH