Fast Facts

Updates for Prevention and Screenings in Women's Health

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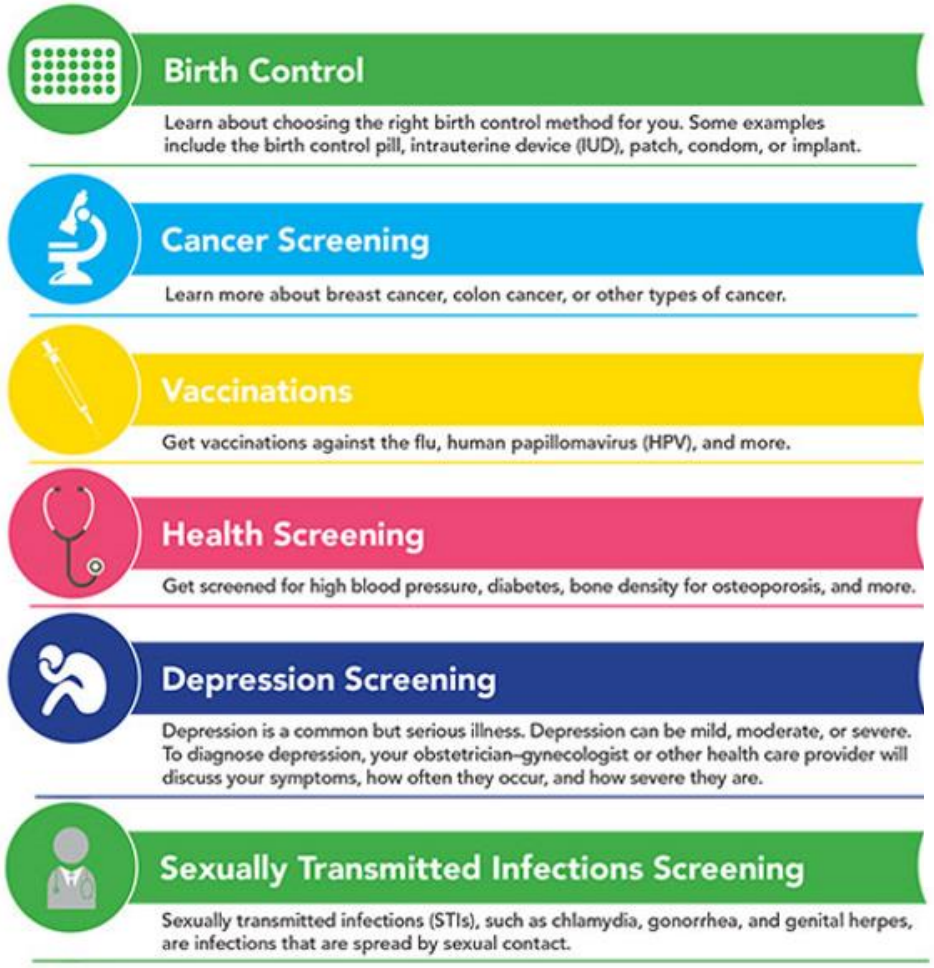
Urology, Women's Health, Sexual Medicine

Skin, Bones, Hearts, and Private Parts 2024

Objectives

- Identify components necessary for an annual wellness visit for AFAB individuals
- Discuss three vital preventative and screening topics
- List two reasons it is important to recognize special populations and considerations for their overall wellbeing.

Annual Wellness Visit



The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

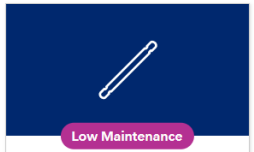
Annual Wellness Visit Specifics

- Ages 13-18
  - School, safety, relationships, contraception, suicide
- Ages 19-39
  - Reproduction, perimenopause, increased risk factors, IPV
- Ages 40-64
  - Perimenopause, menopause, mammography, colonoscopy, osteoporosis
- Ages >65
  - Menopause and risk factors

Should happen at least once a year.

Well-woman visit. ACOG Committee Opinion No. 755. American College of Obstetricians and Gynecologists. Obstet Gynecol 2018;132:e181–86.

Contraception



Low Maintenance

Birth Control Implant

99% Effective

Can cost $0 to $1300

Lasts Up To 5 years

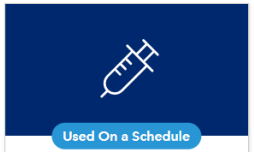
Low Maintenance

IUD

99% Effective

Can cost $0 to $1300

Lasts Up To 3-12 years



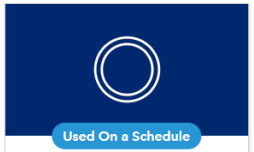
Used On a Schedule

Birth Control Shot

96% Effective

Can cost $0 to $150

Get every 3 months



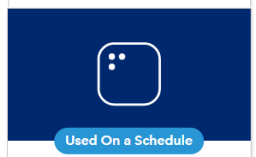
Used On a Schedule

Birth Control Vaginal Ring

93% Effective

Can cost $0 to $200

Put in and take out once a month



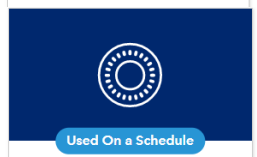
Permanent

Sterilization (Tubal Ligation)

99% Effective

Can cost $0 to $6000

Lasts for Life



Permanent

Vasectomy

99% Effective

Can cost $0 to $1000

Lasts for life

Used On a Schedule

Birth Control Patch

93% Effective

Can cost $0 to $150

Replace weekly

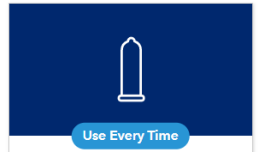
Used On a Schedule

Birth Control Pill

93% Effective

Can cost $0 to $50

Take daily



Use Every Time

Condom

87% Effective

Can cost $0 to $2

Use every time

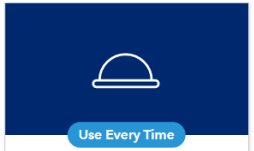
Use Every Time

Internal Condom

79% Effective

Can cost $0 to $3

Use every time



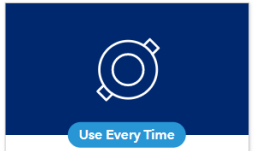
Use Every Time

Diaphragm

87% Effective

Can cost $0 to $75

Use every time



Use Every Time

Birth Control Sponge

78-86% Effective

Can cost $0 to $15

Use every time

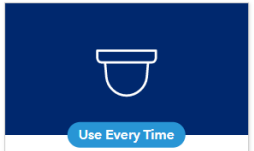
Use Every Time

Spermicide & Gel

79 or 86% Effective

Can cost $0 to $270

Use every time



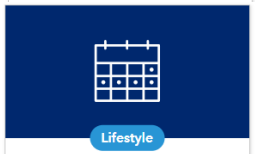
Use Every Time

Cervical Cap

71-86% Effective

Can cost $0 to $90

Use every time



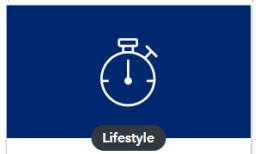
Lifestyle

Fertility Awareness (FAMs)

77-98% Effective

Can cost $0 to $20

Use daily



Lifestyle

Withdrawal (Pull Out Method)

78% Effective

Cost $0

Use Every Time

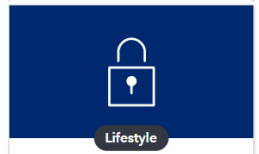
Lifestyle

Breastfeeding as Birth Control

98% Effective

Cost $0

Do every 4-5 hours



Lifestyle

Outercourse and Abstinence

100% Effective

Cost $0

Used every time

phexxi®

(lactic acid, citric acid, and potassium bitartrate) Vaginal Gel 1.8%, 1%, 0.4%

Birth Control, https://www.plannedparenthood.org/learn/birth-control. Accessed February 2, 2023.

Cervical Cancer Screening

- New Guidelines April 2020
- Based on risk strategy – risk tables to guide practice
- Routine screening applies only to asymptomatic individuals who do not require surveillance for prior abnormal screening results
- New Guidelines
  - Recommendations (colposcopy and treatment vs surveillance) are based on risk for CIN 3+
    - Risk determined by prior history as well as screen results
    - Risk tables also address 'unknown history' scenario
  - Deferral of colposcopy: Low risk for CIN 3+ (risk defined by tables)
    - Repeat HPV testing or cotesting at 1 year
    - At the 1-year follow-up test, referral to colposcopy if still abnormal
  - Expansion of expedited treatment category (biopsy not needed prior to therapy), for example, in nonpregnant patients ≥25 years, expedited treatment is
    - Preferred: CIN 3+ risk is ≥60%
    - Preferred: HPV 16–positive HSIL cytology and never or rarely screened patients with HPV-positive HSIL regardless of HPV genotype
    - Acceptable: CIN 3+ risk is between 25% and 60%
    - Shared decision making is important in the context of "impact on pregnancy outcomes"
- Excisional treatment
  - Preferred over ablation for HSIL (CIN 2 or CIN 3) in the US
  - Recommended for AIS
- CIN 1
  - Observation is preferred vs treatment
  - Treatment acceptable with persistent CIN 1 results >2 years
- Lower Anogenital Squamous Terminology (LAST)/World Health Organization (WHO) recommendations for reporting histologic HSIL
  - Include HSIL (CIN 2) and HSIL (CIN 3) (i.e., include CIN 2 and 3 qualifiers)
- Reflex cytology
  - Should be performed on all positive HPV tests, regardless of genotype
  - If HPV 16 and 18 testing is positive but additional laboratory testing of the same sample is not feasible, proceed directly to colposcopy
- Surveillance recommendations following histologic HSIL, CIN 2, CIN 3, or AIS
  - Continue surveillance with HPV testing or cotesting at 3-year intervals for at least 25 years (recommended)
  - >25 years is acceptable "for as long as the patient's life expectancy and ability to be screened are not significantly compromised by serious health issues"
- HPV assays
  - The ASCCP consensus document states the following in reference to HPV tests

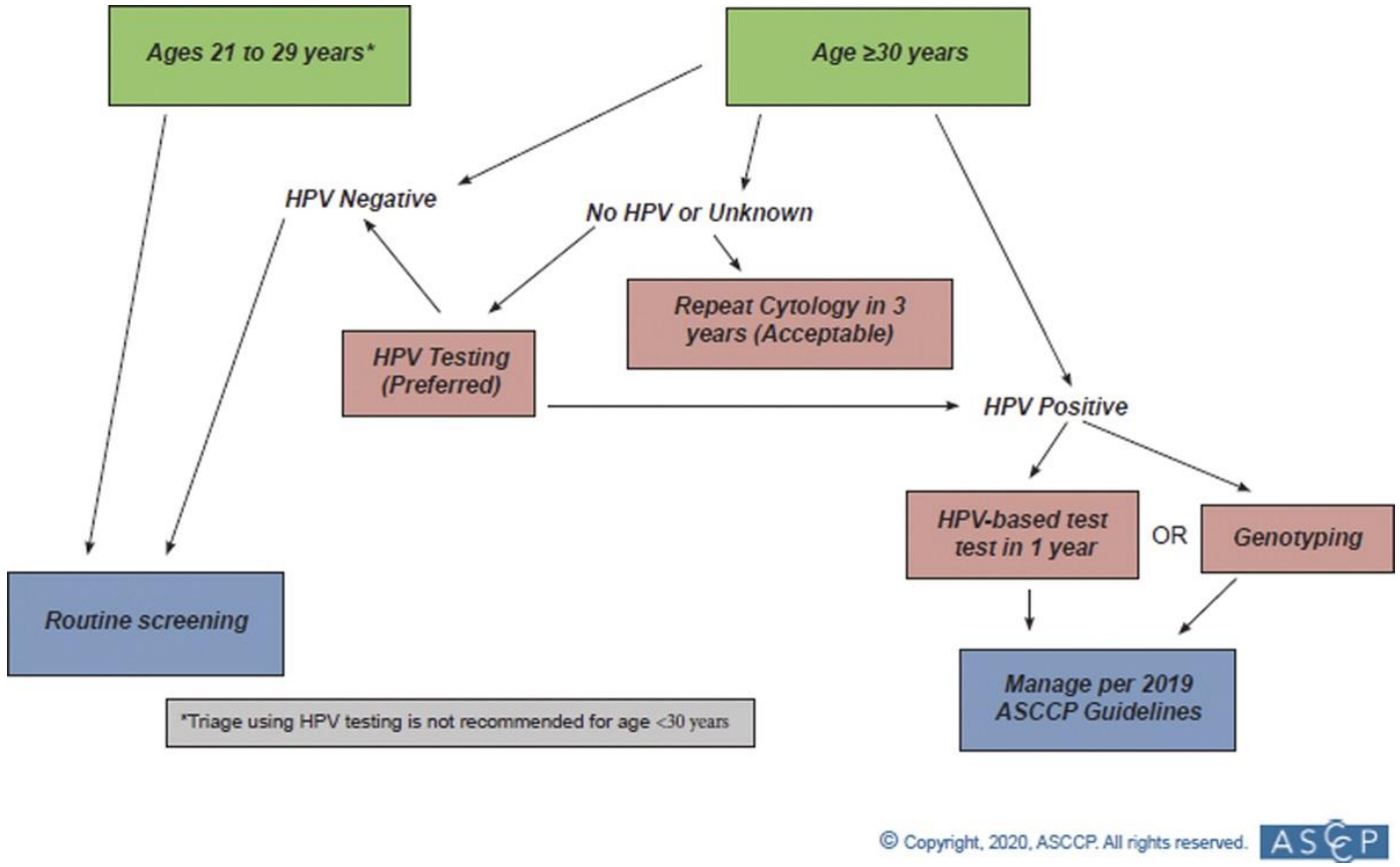
ACOG Updated Cervical Cancer Screening Guidelines April 2021, Reaffirmed April 2024
Perkins R et al. 2019 ASCCP Risk-Based Management Consensus Guidelines Committee 2019 ASCCP Risk-Based Management Consensus Guidelines for Abnormal Cervical Cancer Screening Tests and Cancer Precursors, Journal of Lower Genital Tract Disease: April 2020 - Volume 24 - Issue 2 - p 102-131.
Egemen D et al. Risk Estimates Supporting the 2019 ASCCP Risk-Based Management Consensus Guidelines, Journal of Lower Genital Tract Disease: April 2020 - Volume 24 - Issue 2 - p 132-143.

Cervical Cancer Screening

American Cancer Society	American College of Obstetricians and Gynecologists	U.S. Preventative Services Task Force
Ages 25-65 • Primary hrHPV testing only every 5 years OR • HPV and cytology every 5 years 25-64 years • Cytology alone every 3 years **Ages >65** • Stop if normal testing history and no history of CIN2+	**Ages 21-29** • Cytology alone every 3 years **Ages 30-65** • Preferred = CoTest (hrHPV and cytology) every 5 years • Acceptable = Cytology alone every 3 years • Can be considered = hrHPV screening alone no more frequently than every 5 years **Ages >65** • Stop if normal testing history and no history of CIN2+	**Ages 21-29** • Cytology alone every 3 years **Ages 30-65** • Cytology alone every 3 years • hrHPV testing only every 5 years • CoTest (hrHPV and cytology) every 5 years **Ages >65** • Stop if normal testing history and no history of CIN2+

ASCCP Guidelines, https://www.asccp.org/screening-guidelines. Accessed February 2, 2023.

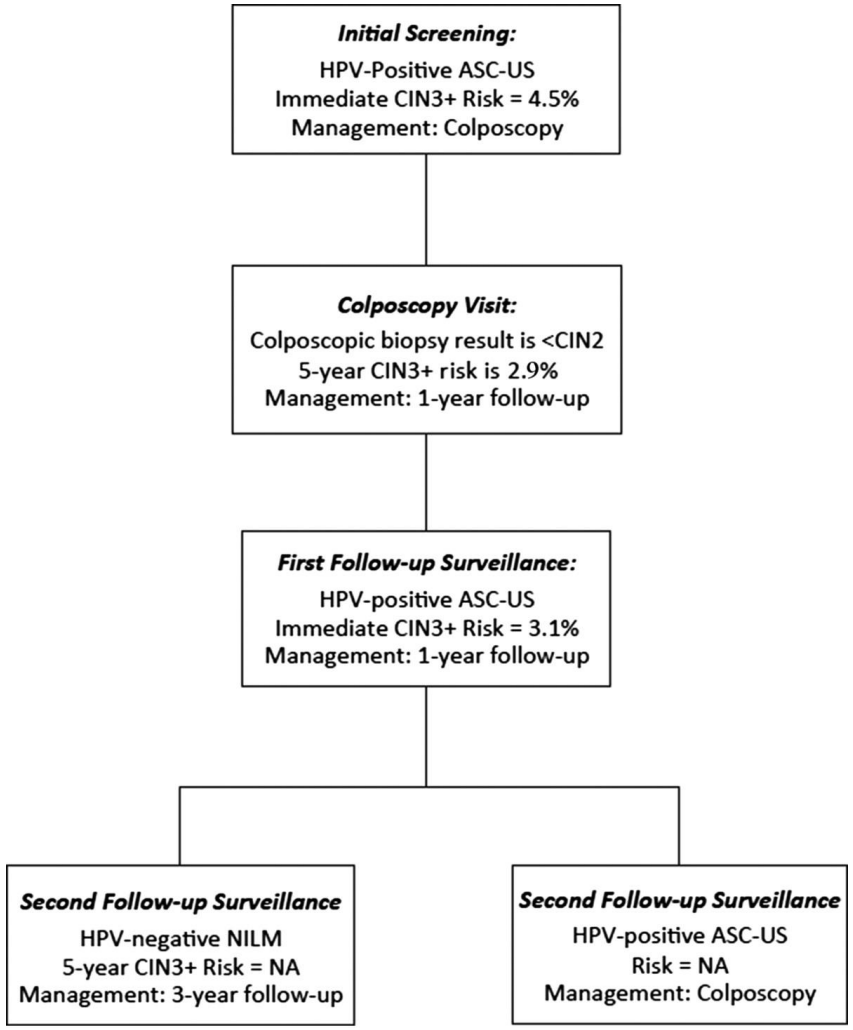
ASCCP management Guidelines

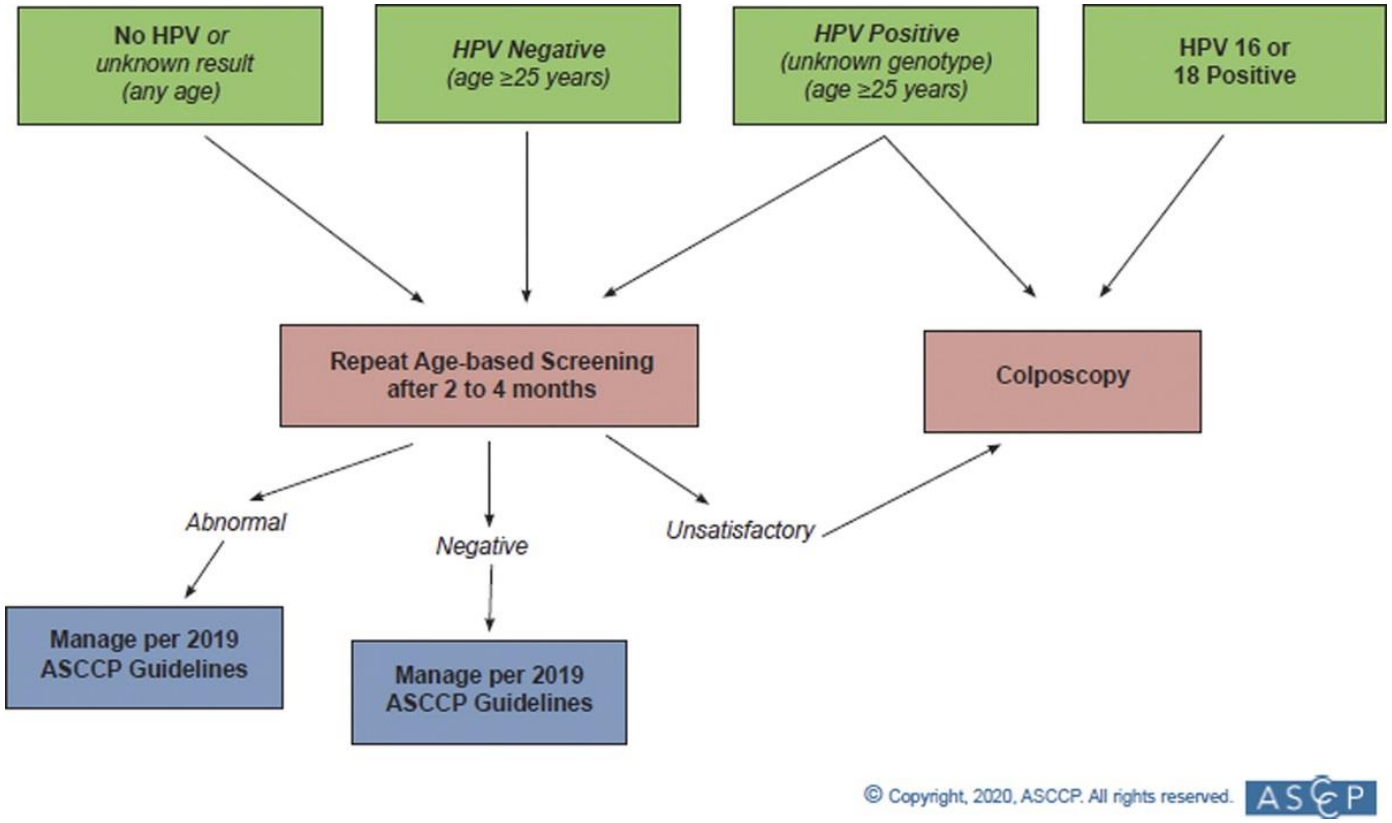


https://www.asccp.org/management-guidelines

ASCCP Guidelines, https://www.asccp.org/screening-guidelines. Accessed February 2, 2023.

ASCCP management Guidelines

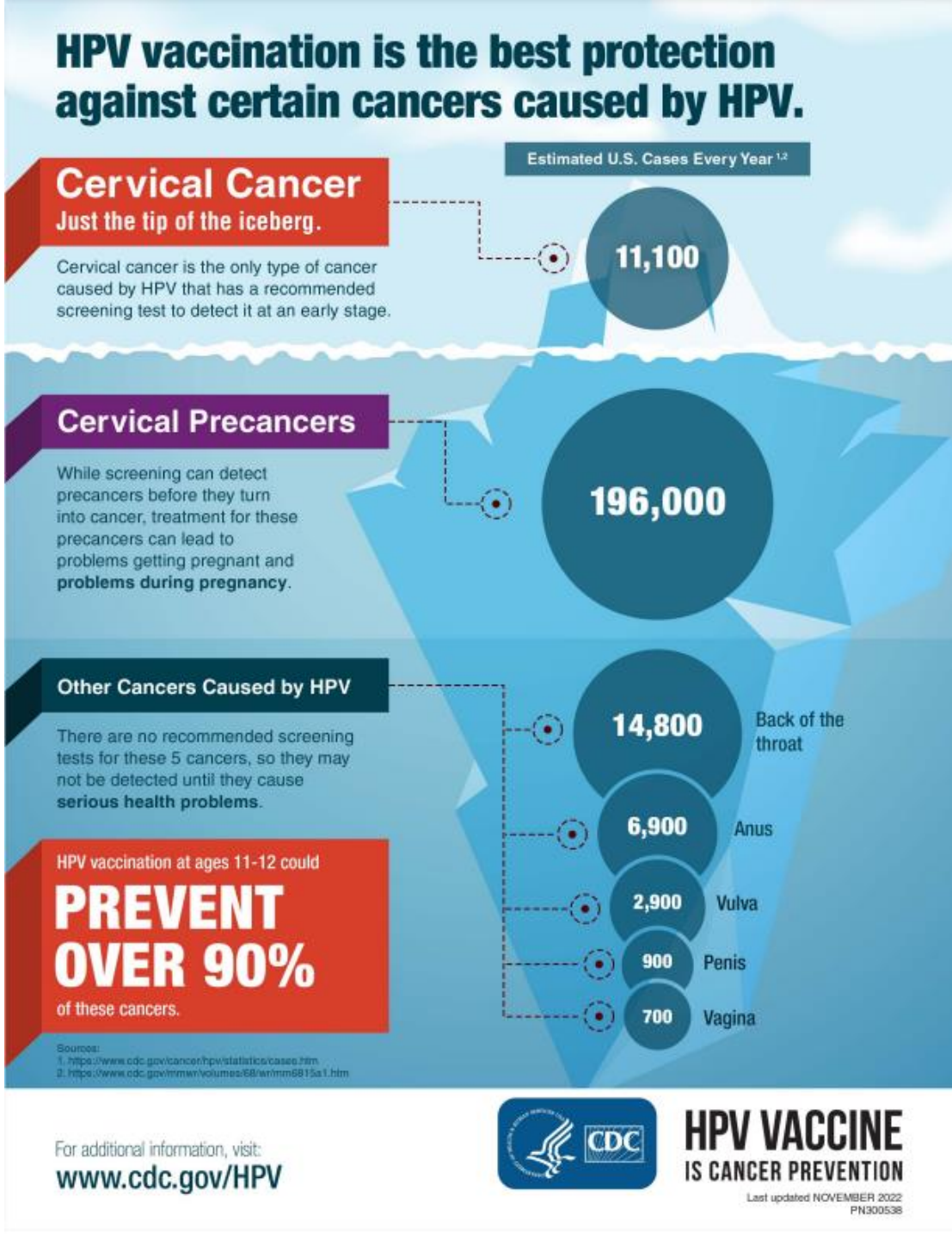




ASCCP Guidelines, https://www.asccp.org/screening-guidelines. Accessed February 2, 2023.

HPV Vaccine

- Every year in the US → 36,500 people
- HPV vaccination could prevent more than 90% of cancers caused by HPV
- When to vaccinate?
  - Routine – Age 11 to 12 years (as early as 9)
  - Catch-up – Age 13 to 26 years
  - Shared decision making – Adults 27 to 45 years
- HPV Vaccine dosing
  - Two doses → 9 to 14 year olds
  - Three does → on or after 15th birthday
- Gardasil 9 valent vaccine
  - Types – 3, 6, 11, 16, 18, 31, 45, 52, 58
- We have identified over 150 strains of HPV!
  - Condyloma acuminatum = HPV-6 and HPV-11 (90%)
  - Cervical cancer = HPV-16 and HPV-18 (70%)
  - Vulvar cancer = HPV-16,HPV-18, and HPV-31 (50%)
  - Oropharyngeal = HPV-16 (60%)
  - Anal = HPV-16 and HPV-18 (90%)
- 9/10 HPV infections will clear <2 years

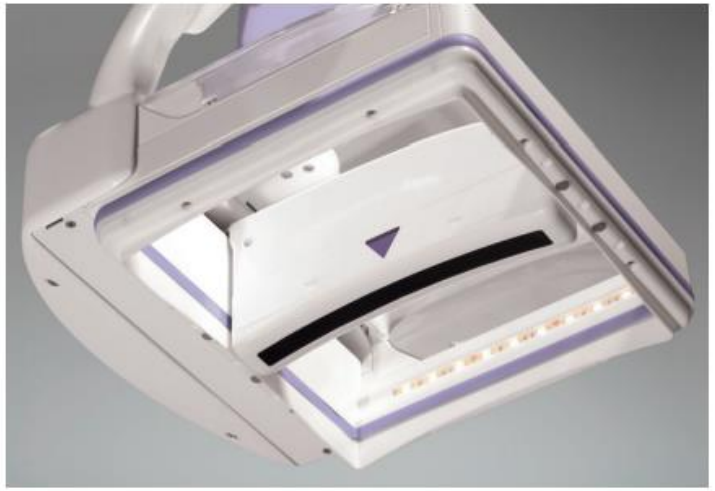


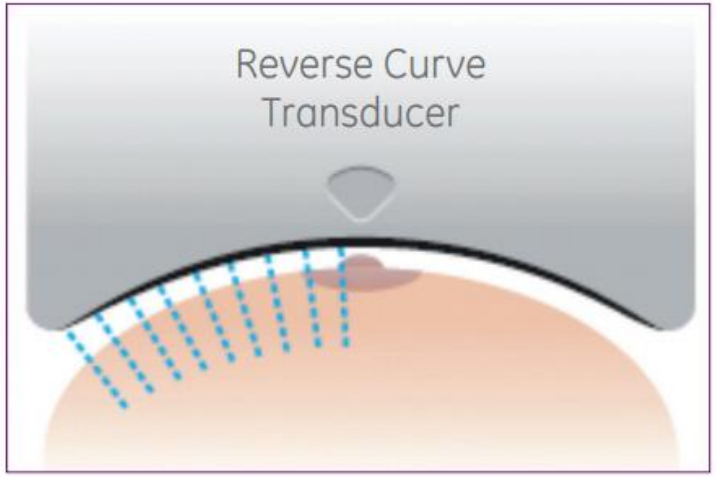
Breast Cancer Screening

American Cancer Society 2023	National Comprehensive Cancer Network 2019	U.S. Preventative Services Task Force 2024	American College of Obstetricians and Gynecologists 2024
Mammography			
Informed decision-making with a health care provider ages 40-44. Every year starting at age 45-54. Every 2 years (or every year if a woman chooses to do so) starting at age 55, for as long as a woman is in good health.	Every year starting at age 40, for as long as a woman is in good health. (3D mammography – breast tomosynthesis – may be considered)	Informed decision-making with a health care provider ages <40. Every 2 years ages 40-74. Insufficient evidence in ages >75.	Offer every year starting at age 40 with average risk – every one to two years. Initiate annually no later than age 50 years. May discontinue at age 75.
Clinical Breast Exam			
Not recommended.	Every 1-3 years ages 25-39. Every year starting at age 40.	Not enough evidence to recommend for or against.	Every 1-3 years ages 25-39. Every year starting at age 40.
Self Breast Exam			
Not recommended	Recommends breast awareness.	Not enough evidence to recommend for or against.	Recommends breast awareness.

Berg WA. USPSTF Breast Cancer Screening Guidelines Do Not Go Far Enough. *JAMA Oncol.* Published online April 30, 2024. doi:10.1001/jamaoncol.2024.0905

Breast Cancer Screening – ABUS





Having dense breasts increases a woman's likelihood to develop cancer four to six times.

BI-RADS Classification. www.acr.org. Accessed December 3, 2018.

Tice J, Migloioretti D, Li C, et al. Breast density and benign breast disease: risk assessment to identify women at high risk of breast cancer. J Clin Oncol 2015; 33:3137-43.

Evaluation of a Breast Mass

- Discovered by partner or self breast exam, CBE, or screening mammography
- History
  - How long has mass been there?
  - Nipple discharge or skin changes?
  - Trauma or injury to the area?
  - Medications?
  - Relationship to menstrual cycle?
  - Family history of breast disease
- Physical exam – if not found by provider on CBE, a thorough exam and inspection should be performed
  - Size, shape, consistency, mobility, location
- Diagnostic imaging
  - Under age 30 – breast US
  - Over 40 – diagnostic mammography with breast US as indicated
  - MRI reserved for high-risk patients
- Breast Imaging Reporting and Data System (BI-RADS) to determine need for biopsy
  - Solid masses need biopsy
    - FNA with/without US guidance
    - Core needle biopsy
    - Surgical biopsy

BI-RADS Classification	
0:	Unsatisfactory assessment – additional imaging needed
1:	Negative findings – routine follow-up recommended
2:	Benign findings – no malignancy suspected
3:	Probably benign lesion – short term follow-up indicated
4:	Suspicious abnormality
5:	Highly suggestive of malignancy
6:	Known malignancy

Guray M, Sahin A. Benign breast diseases: classification, diagnosis, and management. Oncologist 2006; 11:435-49.

Benign Breast Disease

Nonproliferative Breast Lesions (Breast Cancer Risk = 1.27)	
Breast cyst (simple)	Round, ovoid fluid-filled masses; firm, mobile, well-demarcated; premenopausal women (age 35-50); influenced by hormonal changes; acute enlargement can cause pain
Complex cyst	Thick walls and/or septa >0.5mm on US; anechoic or echogenic; Dx with FNA/core biopsy/surgery
Mild hyperplasia of usual type	Increase in number of epithelial cells within a duct; Dx with FNA/core biopsy/surgery
Proliferative Breast Lesions without Atypia (Breast Cancer Risk = 1.88)	
Fibroadenoma	Mixed fibrous and glandular tissue; aberration of normal breast development; smooth, firm, rubbery, mobile mass; common age 15-35; Dx with core biopsy/surgery
Juvenile fibroadenoma	Unilateral, painless, rapidly growing solitary mass >5cm; ages 10-18; Tx with surgical excision
Intraductal papilloma	Wart-like growth in lactiferous ducts; small lump near nipple with clear/bloody discharge; ages 35-50; Dx with core biopsy; Tx observation vs surgical excision
Usual ductal hyperplasia	Increase in number of cells in duct without atypia, incidental finding on biopsy
Radial scars	AKA complex sclerosing lesion; fibroelastic core with radiating ducts and lobules; incidental finding
Proliferative Breast Lesions with Atypia (Breast Cancer Risk = 4.24)	
Atypical hyperplasia	Proliferation of dysplastic cells in ducts or lobules; 10% of biopsies; pre-malignant; Dx core biopsy; Tx with surgical excision; increased screening follow-up; avoid hormones; chemoprevention in select women

Guray M, Sahin A. Benign breast diseases: classification, diagnosis, and management. Oncologist 2006; 11:435-49.

Intimate partner violence (IPV)

- U.S. Preventive Service Task Force (USPSTF) Recommendation:
  - Screen women of childbearing age for intimate partner violence (IPV), such as domestic violence (DV), and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse.
- According to the CDC, roughly 1.5 million women are raped and/or physically assaulted each year in the United States.
- IPV affects as many as 324,000 pregnant women each year.
- USPSTF screenings are directed at patients and can be self-administered or used in a clinician interview format.
- The 6 tools that showed the most sensitivity and specificity were:
  - HITS (Hurt, Insult, Threaten, Scream)
  - OVAT (Ongoing Violence Assessment Tool)
  - STaT (Slapped, Things and Threaten)
  - HARK (Humiliation, Afraid, Rape, Kick)
  - CTQ-SF (Modified Childhood Trauma Questionnaire–Short Form)
  - WAST (Woman Abuse Screen Tool)
- Other screening tools for pregnant women include 4 Ps and the Abuse Assessment Screen. CDC has compiled a comprehensive list of screening instruments that have been tested on various patient populations.
- Studies have shown that patient self-administered, or computerized screenings are as effective as clinician interviewing in terms of disclosure, comfort, and time spent screening.

Centers for Disease Control, Intimate Partner Violence, https://www.cdc.gov/media/presskits/aahd/violence.pdf

Intimate Partner Violence

- Barriers
  - Time constraints
  - Discomfort with the topic
  - Fear of offending the patient or partner
  - Need for privacy
  - Perceived lack of power to change the problem
  - A misconception regarding patient population's risk of exposure to IPV

www.thehotline.org
1-800-799-7233

Centers for Disease Control, Intimate Partner Violence, https://www.cdc.gov/media/presskits/aahd/violence.pdf

Bone Density Screening

- By 2020, approximately 12.3 million individuals in the United States older than 50 years are expected to have osteoporosis.
- Osteoporotic fractures, particularly hip fractures, are associated with limitations in ambulation, chronic pain and disability, loss of independence, and decreased quality of life, and 21% to 30% of patients who experience a hip fracture die within 1 year.
- The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.
- The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.
- The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for osteoporosis to prevent osteoporotic fractures in men.
  - Endocrine Society recommends for men ages >70 years
- ACOG recommends selective screening in postmenopausal women younger than 65 years who have osteoporosis risk factors or an adult fracture

Medications that may cause bone loss:
Steroid medications
Thyroid hormones
Anti-seizure medicines
Aromatase Inhibitors
Certain cancer medications
Gonadotropic releasing hormone (GnRH)
Proton Pump Inhibitors
Selective Serotonin Reuptake Inhibitors (SSRIs)
Thiazolidinediones
Depo-Provera®

USPSTF Recommendation Statement: Screening for Osteoporosis to Prevent Fractures. JAMA. 2018;319(24):2521-2531.

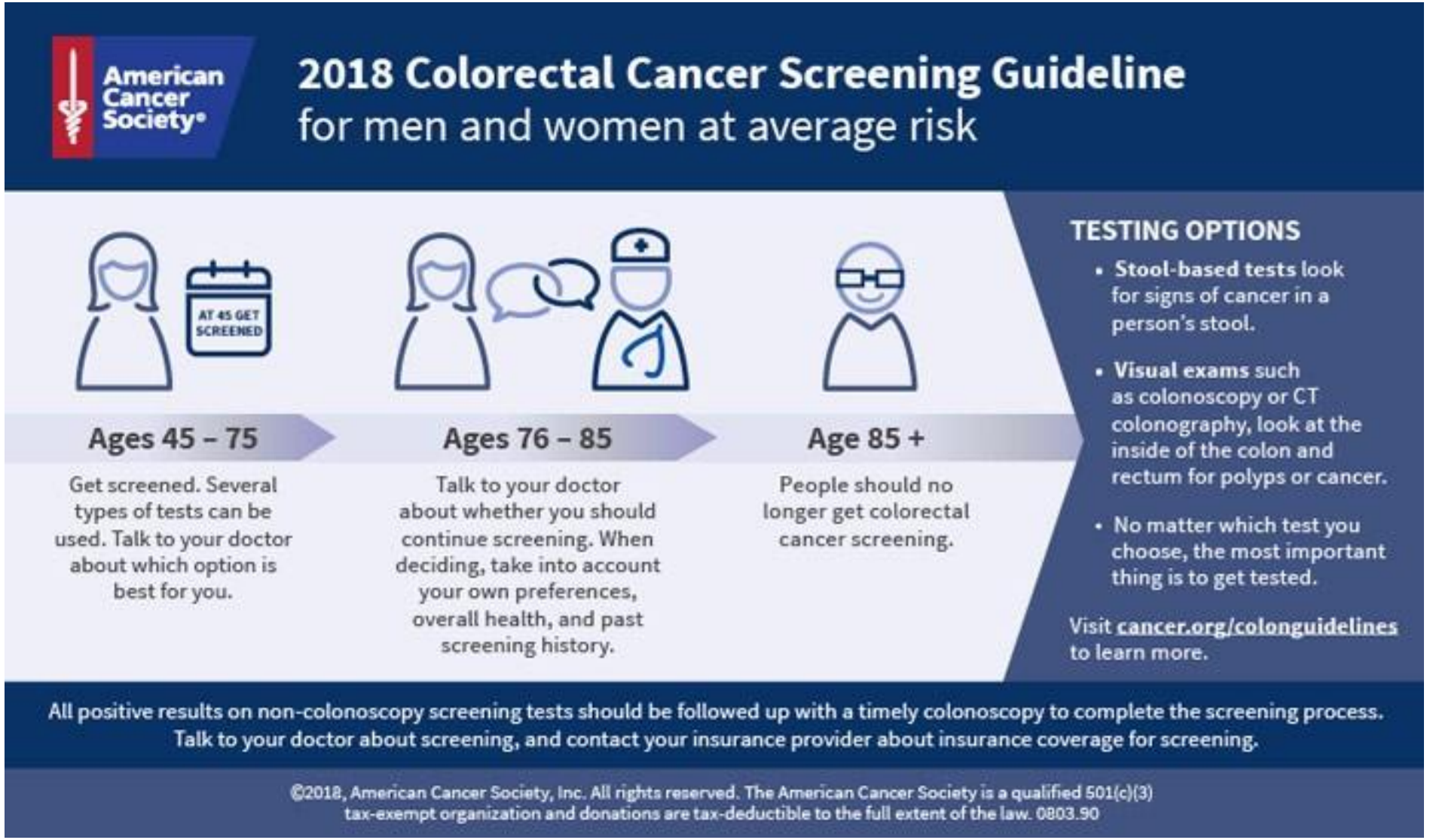
Bone Density Screening

National Osteoporosis Foundation 2014	America Association of Clinical Endocrinologists (AACE) 2020	U.S. Preventative Services Task Force 2018	American College of Obstetricians and Gynecologists 2018
Women over the age of 65 Men over the age of 70 If you break a bone after age 50 Menopausal age with risk factors Postmenopausal under age 65 with risk factors Men aged 50-69 with risk factors	Clinical Practice Guidelines for the Diagnosis and Treatment of Postmenopausal Osteoporosis 2020 All women >65 years of age Women <65 with risk factors: Risk factors for falling Early menopause Smoking/Alcohol Height loss kyphosis Long-term systemic glucocorticoid therapy	All women >65 years of age Women at increased risk for fractures, beginning at age 60 Not enough evidence to support men being screened unless risk factors are present.	All women >65 years of age Women younger than 65 with the following risk factors: History of fragility fracture Body weight less than 127 lbs Medical causes of bone loss Parental history of hip fracture Current smoker Alcoholism Rheumatoid arthritis

The FRAX® Tool at www.shef.ac.uk/FRAX

USPSTF Recommendation Statement: Screening for Osteoporosis to Prevent Fractures. JAMA. 2018;319(24):2521-2531.

Colon Cancer Screening



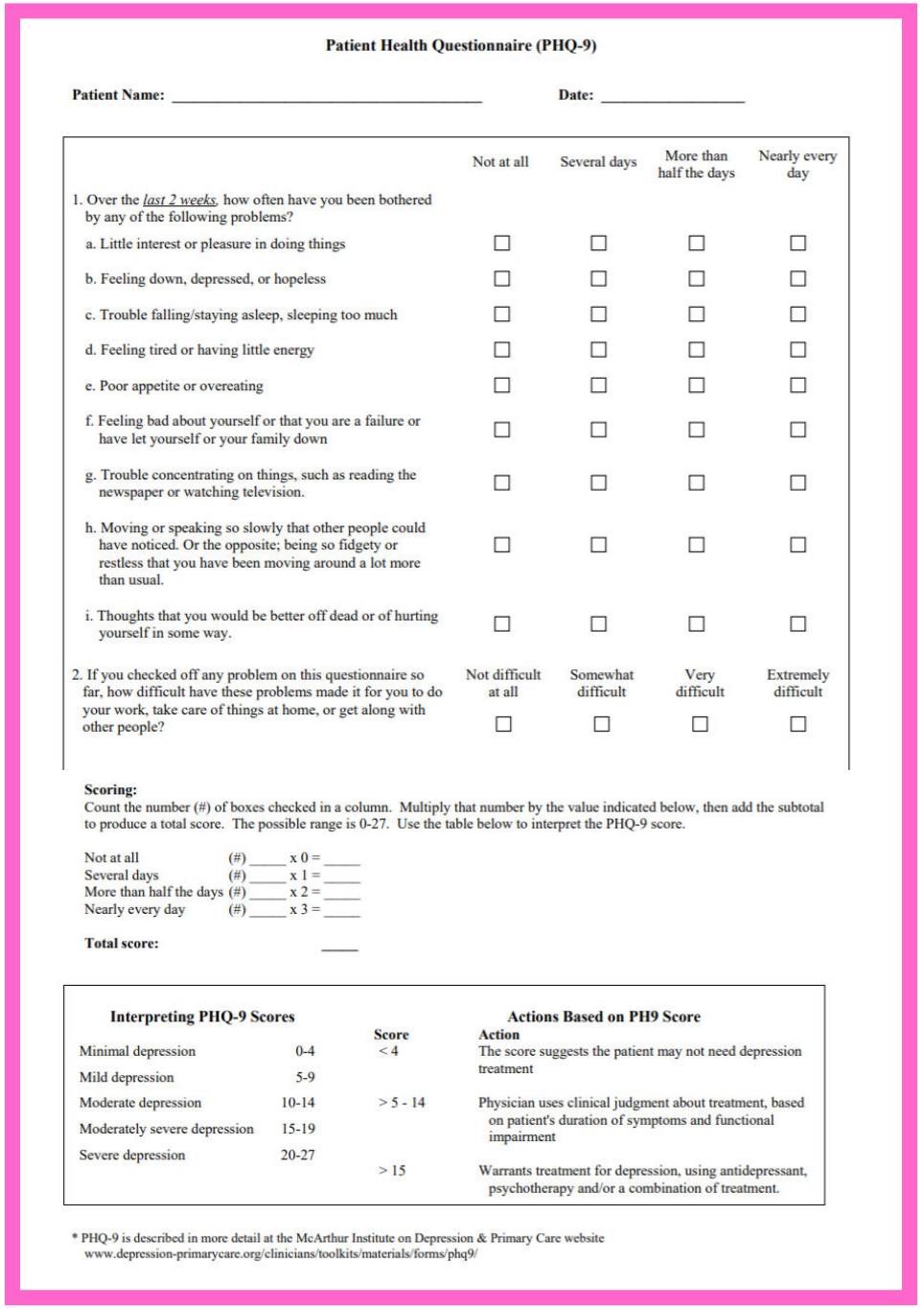
Colon Cancer Screening

- People at average risk of colorectal cancer should start regular screening at age 45.
- People who are in good health and with a life expectancy of more than 10 years should continue regular colorectal cancer screening through the age of 75.
- People ages 76 through 85 should make a decision with their medical provider about whether to be screened, based on their own personal preferences, life expectancy, overall health, and prior screening history.
- People over 85 should no longer get colorectal cancer screening.
- What are the tests?
  - Stool-based tests:
    - Highly sensitive fecal immunochemical test (FIT) every year
    - Highly sensitive guaiac-based fecal occult blood test (gFOBT) every year
    - Multi-targeted stool DNA test (MT-sDNA) every 3 years
  - Visual exams:
    - Colonoscopy every 10 years
    - CT colonography (virtual colonoscopy) every 5 years
    - Flexible sigmoidoscopy (FSIG) every 5 years

2021 Updates to Colon Cancer Screening, American Cancer Society, https://www.cancer.org/latest-news/american-cancer-society-updates-colorectal-cancer-screening-guideline.html, accessed May 3, 2024

Depression

- The USPSTF recommends screening in all adults regardless of risk factors.
- Among older adults, risk factors for depression include disability and poor health status related to medical illness, complicated grief, chronic sleep disturbance, loneliness, and a history of depression.
- Risk factors for depression during pregnancy and postpartum
  - poor self-esteem
  - child-care stress
  - prenatal anxiety
  - life stress
  - decreased social support
  - single/unpartnered relationship status
  - history of depression
  - difficult infant temperament
  - previous postpartum depression
  - lower socioeconomic status
  - unintended pregnancy.



Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

Scoring:
Count the number (#) of boxes checked in a column. Multiply that number by the value indicated below, then add the subtotal to produce a total score. The possible range is 0-27. Use the table below to interpret the PHQ-9 score.

Not at all (#) _____ x 0 = _____
Several days (#) _____ x 1 = _____
More than half the days (#) _____ x 2 = _____
Nearly every day (#) _____ x 3 = _____

Total score: _____

Interpreting PHQ-9 Scores		Score	Actions Based on PH9 Score Action
Minimal depression	0-4	< 4	The score suggests the patient may not need depression treatment
Mild depression	5-9		
Moderate depression	10-14	> 5 - 14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment
Moderately severe depression	15-19		
Severe depression	20-27		
		> 15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment.

* PHQ-9 is described in more detail at the McArthur Institute on Depression & Primary Care website www.depression-primarycare.org/clinicians/toolkits/materials/forms/phq9/

Screening for Depression in Adults US Preventive Services Task Force Recommendation Statement. JAMA January 26, 2016 Volume 315, Number 4.

Anxiety

- Women are twice as likely as men to be diagnosed with anxiety disorder in their lifetime
  - 23.4% women vs 14.3% men
- Generalized anxiety disorder, panic attacks, and PTSD
- Signs and Symptoms:
  - Feeling nervous, irritable, or on edge
  - Sense of impending danger, panic, or doom
  - Increased heart rate, rapid breathing, sweating, trembling
  - Feeling weak or tired
  - Difficulty concentrating or avoidance
  - Trouble sleeping
  - Gastrointestinal problems

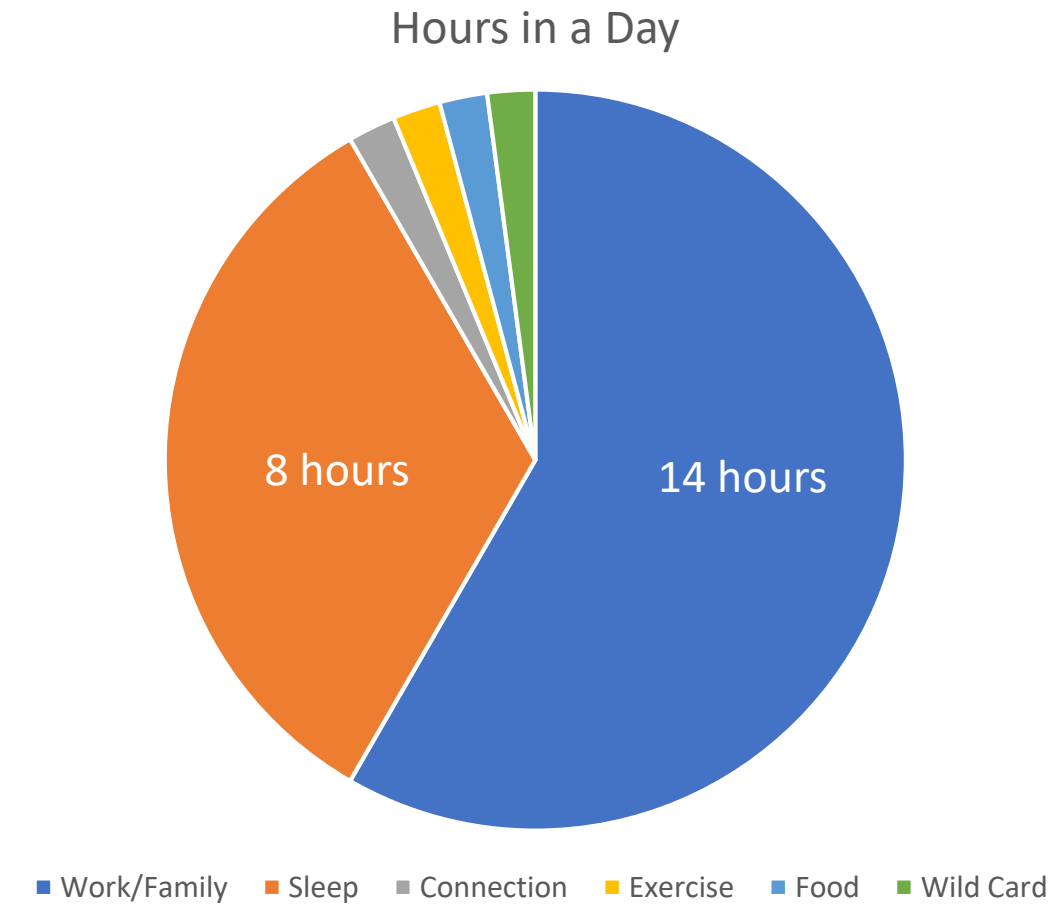
GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

National Institute of Mental Health, Any Anxiety Disorder, https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder, Accessed February 2, 2023.

Sleep

- National Sleep Foundation recommends 7-9 hours of sleep per night for an adult
- Not current guidelines by ACOG, NAMS, USPSTF
- Should we screen for sleep issues and concerns?
- Short sleep and disturbed sleep is a causal factor for 20 percent of serious car accidents
- Poor sleep is a better predictor of developing DMT2 than lack of physical activity
- Inadequate sleep impairs brain functioning
- Cognitive and motor functioning
- 12% greater risk of mortality with fewer than 5-6 hours every night
- What is adequate?
  - 42% of your day should be reserved for rest = 10 hours



Nagoski E and Nagoski A. Burnout: The secrete to unlocking the stress cycle. 2019.

STIs

Chlamydia

Women	• Sexually active women under 25 years of age[1] • Sexually active women 25 years of age and older if at increased risk*[1] • Retest approximately 3 months after treatment[2] • Rectal chlamydial testing can be considered in females based on reported sexual behaviors and exposure, through shared clinical decision between the patient and the provider[2,3,4]

Gonorrhea

Women	• Sexually active women under 25 years of age[1] • Sexually active women 25 years of age and older if at increased risk*[1] • Retest 3 months after treatment[2] • Pharyngeal and rectal gonorrhea screening can be considered in females based on reported sexual behaviors and exposure, through shared clinical decision between the patient and the provider[2,3,4]

Trichomonas

Women	• Consider screening for women receiving care in high-prevalence settings (e.g., STI clinics and correctional facilities) and for asymptomatic women at high risk for infection (e.g., women with multiple sex partners, transactional sex, drug misuse, or a history of STI or incarceration)[2]

Sexually Transmitted Infections Treatment Guidelines, 2021, CDC, June 6, 2022, https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm

STIs

Syphilis

Women	• Screen asymptomatic women at increased risk (history of incarceration or transactional sex work, geography, race/ethnicity) for syphilis infection[2,7]

Herpes†

Women	• Type-specific HSV serologic testing can be considered for women presenting for an STI evaluation (especially for women with multiple sex partners)[2]

Hepatitis B Screening

Women	• Women at increased risk (having had more than one sex partner in the previous 6 months, evaluation or treatment for an STI, past or current injection-drug use, and an HBsAg-positive sex partner)[17]

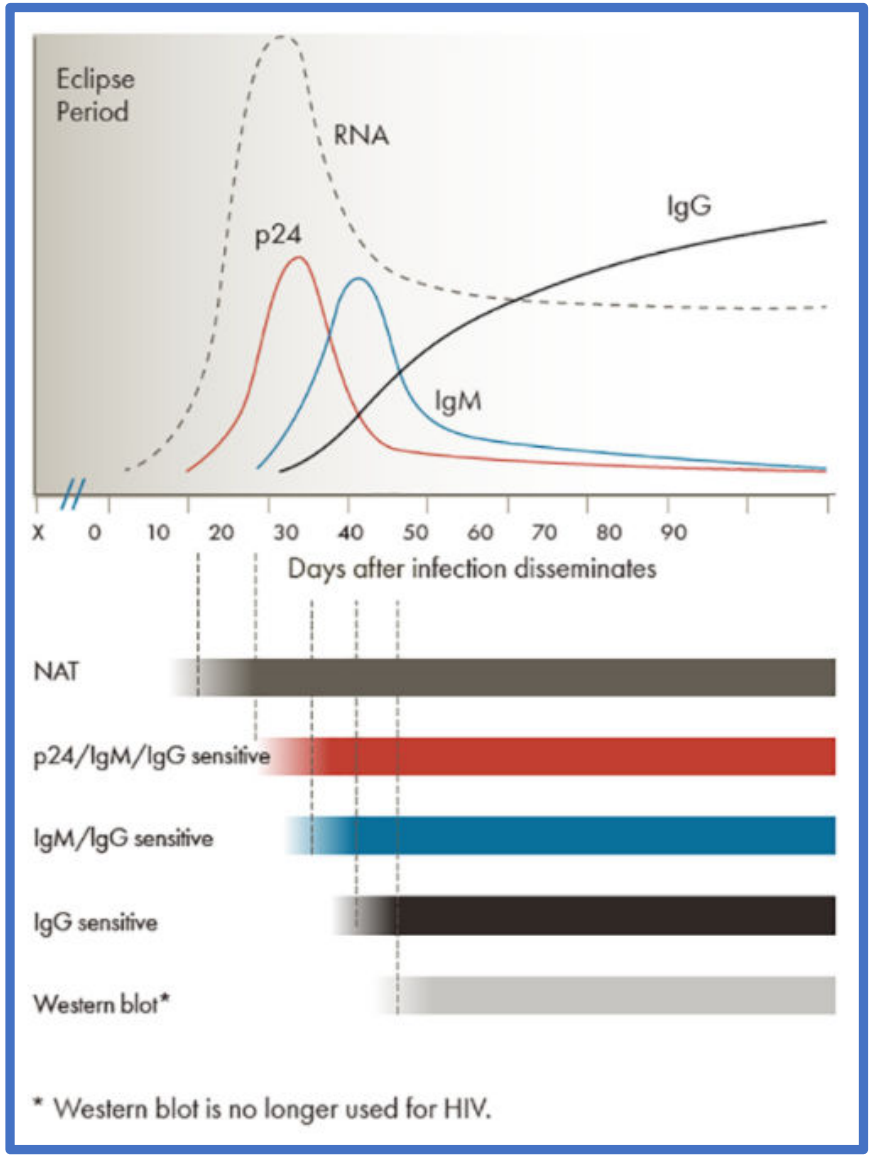
Hepatitis C Screening

Women	• All adults over age 18 years should be screened for hepatitis C except in settings where the hepatitis C infection (HCV) positivity is < 0.1%[19]

Sexually Transmitted Infections Treatment Guidelines, 2021, CDC, June 6, 2022, https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm

HIV Screening

- An estimated 1.1 million people in the United States have HIV and approximately 1 in 7 (nearly 15%) are unaware of their status
- About 40% of new HIV infections are transmitted by people undiagnosed and unaware they have HIV
- CDC recommends that EVERYONE between the ages of 13 and 64 get tested for HIV at least once as part of routine health care
- For those at higher risk, CDC recommends getting tested at least once a year
- Missed opportunities
  - More than 75% of patients at high risk for HIV who saw a PCP in the last year weren't offered an HIV test during their visit.
- Treatment
  - PrEP – Pre-Exposure Prophylaxis
  - PEP – Post-Exposure Prophylaxis
  - Active HIV/AIDS



Sexually Transmitted Infections Treatment Guidelines, 2021, CDC, June 6, 2022, https://www.cdc.gov/std/treatment-guidelines/screening-recommendations.htm

Other Considerations

- Gender Non-Conforming
- Trans-Identified
- Queer folx

Bass B, Nagy H. Cultural Competence in the Care of LGBTQ Patients. [Updated 2022 Oct 3]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 January. Available from: https://www.ncbi.nlm.nih.gov/books/NBK563176/

Questions?

Thank you!

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