Women's Health Seminar

DAY 1: SESSIONS 1 – 3

26 January 2023, 1000 ET – 1400 ET

Seminar Overview

26 January 2023: Day 1

- 1000 ET: Opening Remarks; CDR Heather Hauck
- 1010 ET: Preventative Healthcare for Service Women; LCDR Jody Joynt
- 1130 ET: Understanding Common Women's Health Concerns; LT Adrienne Gillis
- 1300 ET: Women's Health Considerations Prior to and During Deployment; CDR Carolyn Ellison
- 1400 ET: End of Day Remarks; CDR Heather Hauck

27 January 2023: Day 2

- 1000 ET: Opening Remarks; LCDR Ayeetin Azah
- 1010 ET: Ongoing Efforts Led by the OWH and FFR NMOCC; LCDR Allison Eubanks
- 1100 ET: Mental Healthcare and Substance Abuse; CDR Heather Shibley
- 1230 ET: Transgender Healthcare; CDR Janelle Marra and LCDR Amanda Bucknum
- 1400 ET: Closing Remarks; LCDR Ayeetin Azah

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You must register by 1300 ET on January 28th to qualify for the receipt of CE/CME credit or certificate of attendance. *Please complete the following steps to obtain CE/CME credit:*

- Go to https://www.dhaj7-cepo.com/
- If you have previously used the CEPO CMS, click login.
  - Search for your course (2023 Virtual Women's Health Seminar) using the Catalog, Calendar, or Find a course search tool.
  - Click on the REGISTER/TAKE COURSE tab.
  - PASSCODE (if required): WH2023
- If you have not previously used the CEPO CMS, click REGISTER to create a new account. Once you create your account follow steps 2a-c.
- Following the Seminar, you must complete the program posttest and evaluation before collecting your certificate. The posttest and evaluation will be available through **February 10th at 2359 ET**.
- Follow the onscreen prompts to complete the post-activity assessments:
  - Read the Accreditation Statement
  - Complete the Evaluation
  - Take the Posttest
- After completing the posttest at 80% or above, your certificate will be available for print or download.
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Women's Health Seminar

SESSION 1: PREVENTATIVE HEALTHCARE FOR SERVICE WOMEN

LCDR Jody Joynt, M.D.

Staff, Gynecologic Surgery and Obstetrics

Naval Air Station Jacksonville, FL

Presenter: LCDR Jody Joynt

- LCDR Jody Joynt, M.D.
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- Jacksonville, FL

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Learning Objectives

LEARNING OBJECTIVES

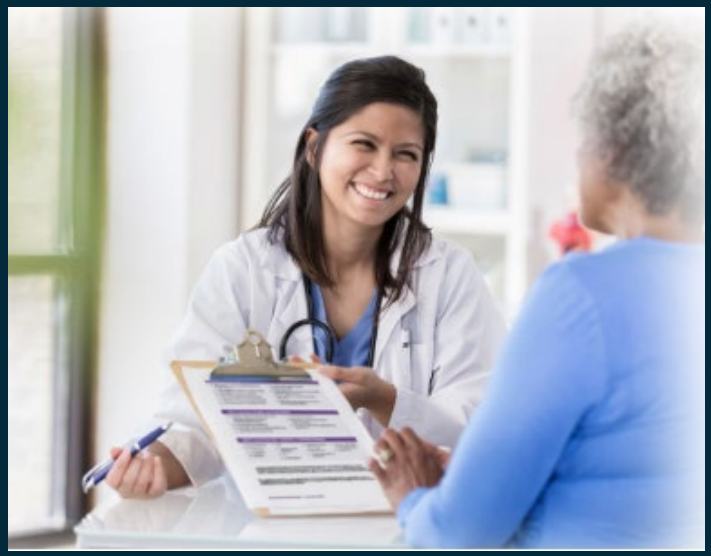
- Review well woman examination
- Review key elements for obtaining a **sexual history** and be able to address sexual health concerns
- Overview of sexually transmitted infections
- Discuss **common mental health** diagnoses and resources available
- Discuss routine **critical health screenings** (cervical cancer, breast cancer)

Well Woman Examination

Well Woman Examination

Overview of Components of Comprehensive Care

- **Comprehensive history**
- **Physical exam** as indicated
- **Age-based and risk-based:**
  - Screening
    - Cervical Cancer
    - Intimate Partner Violence
    - Preventative Health
  - Evaluation
  - Counseling
  - Immunizations
- Counsel regarding healthy lifestyle and minimizing health risks



womenshealth.gov

Well Woman Examination

Comprehensive History

COMPREHENSIVE HISTORY

- **Past medical, surgical, family, social, medications, allergies, reproductive, gynecologic, sexual and mental health history**
- **Gynecologic History**
  - Type of contraception, past and current
  - Screening for intimate partner violence
  - Screening for mental health conditions
  - Screening for sexual practices
  - History of pelvic, vaginal, or vulvar infections – STI, PID, pain
  - Cervical cytology (Pap) history and management – Date and result of last test
  - Review of gynecologic problems, diagnosis, treatment (ovarian cysts, uterine fibroids, infertility, endometriosis, or polycystic ovarian syndrome)
  - Review of gynecologic procedures (indication, complications) (e.g., endometrial biopsy, laparoscopy, hysterectomy)
  - Review of symptoms of pelvic organ prolapse or urinary or anal incontinence

Well Woman Examination

Comprehensive History Continued

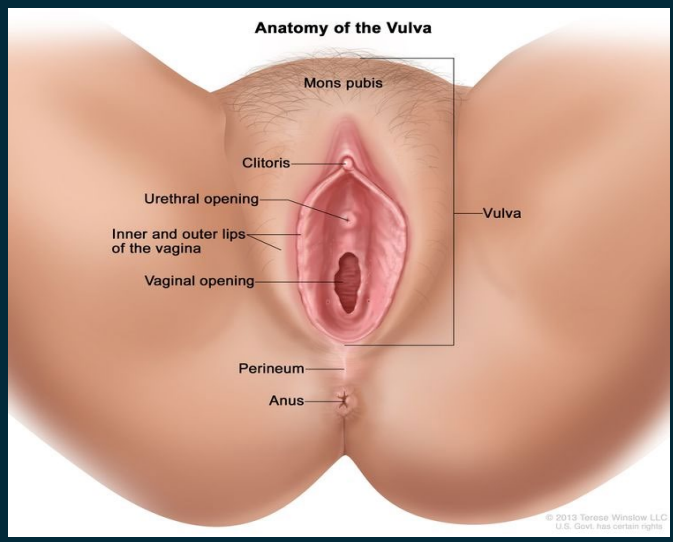
COMPREHENSIVE HISTORY

- **Obstetric history:**
  - Gravida (number of pregnancies)
  - Para (TPAL - number of **term** births; number of **preterm** births from 20 to <37 weeks of gestation; number of **abortions**, failed or terminated pregnancies at <20 weeks; **living** children), eg, G2P2112.
  - A delivery with multiple gestations counts as one birth event (para = 1)
- **Routine Preventative Care:**
  - "Provides an opportunity time to counsel patients about maintaining healthy lifestyle and minimizing health risks"
  - Health Maintenance
    - As indicated: Mammogram, colonoscopy, DEXA, lipid panel, mental health screenings (alcohol use, depression, anxiety)

Well Woman Examination
Pelvic Exam

Pelvic Exam

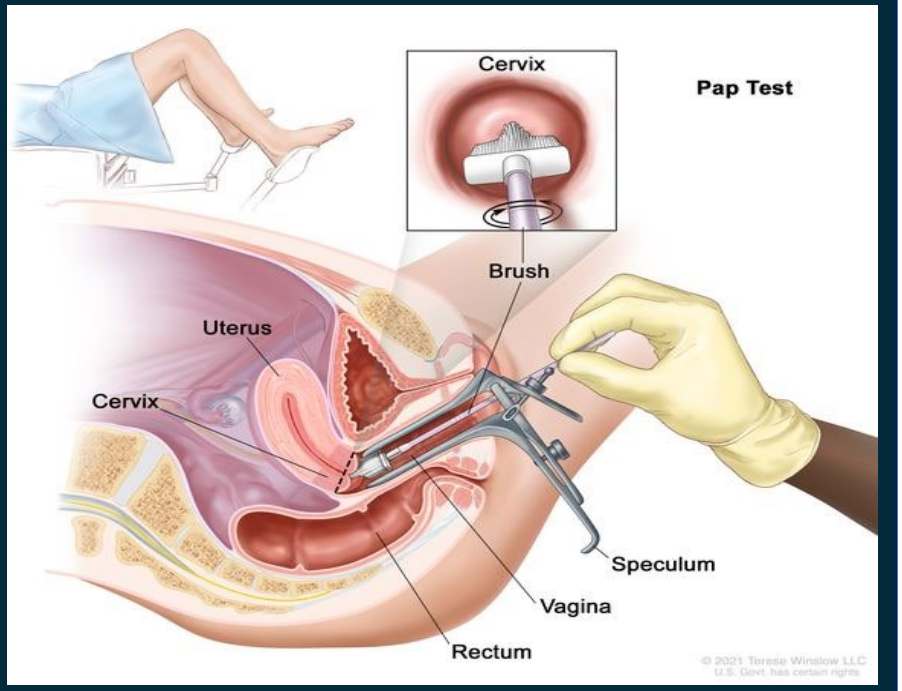
- **No longer recommend annual pelvic examinations** and advise shared-decision making (American Congress of Obstetricians and Gynecologists (ACOG))
- Perform to evaluate **gynecologic** symptoms or concerns, assessing for dyspareunia and sexual dysfunction, perform PAP/HPV testing, or to screen for STIs (or self-swab/urine)
- Stand-by required for pelvic exams.
  - **External genitalia**: inspect and palpate.
    - Note hair distribution, skin, labia minora/majora, perineal body, clitoris, urethral meatus, vestibule and introitus.
    - Evaluate for developmental abnormalities, skin lesions, masses, trauma, infection
  - **Speculum examination**
  - **Bimanual examination**



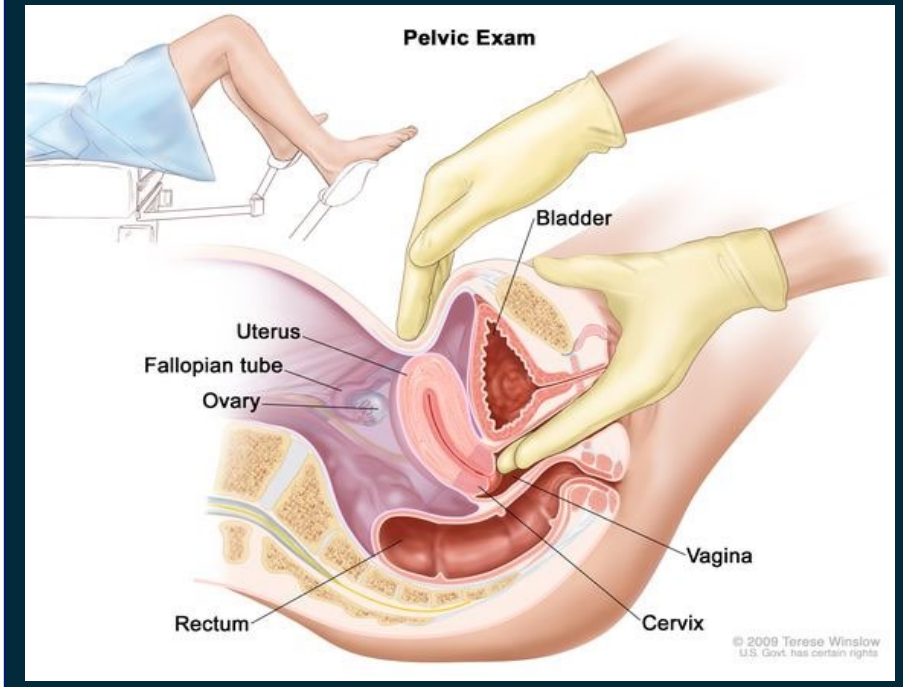
Vulvar anatomy | *Source: cancer.gov*

Well Woman Examination

Speculum and Bi-manual Examination



Speculum Exam Technique | *Source: cancer.gov*



Bi-Manual Exam | *Source: cancer.gov*

Well Woman Examination

Cervical Cancer and PAP Tests

Cervical Cancer and PAP Test

Refer to **ASCCP** (American Society of Cervical Cytology Pathology) App:

General **Guidelines:**

- **Age < 21**: DO NOT SCREEN (rare instances of indicated screening)
- **Age 21-29**: Initiate cervical cancer screening @ 21 years with cervical cytology every 3 years (regardless of HPV vaccination status)
  - **> Age 25**: complete HPV reflex testing (will test if abnormal result on cytology)
- Age **30-65**: Co-testing (Pap and HPV testing) every five years OR Pap test alone every three years; Primary HPV testing (with Food and Drug Administration (FDA)-approved test) every five years (not offered in military system yet)

Photo | Source: hawaiipacifichealth.org

Well Woman Examination

Cervical Cancer Screening Recommendations

American Society for Colposcopy and Cervical Pathology (ASCCP) recommendations were updated in 2019/2020

- DOWNLOAD THE ASCCP MANAGEMENT GUIDELINES APP FOR $10

COLPOSCOPY

- Can be deferred for repeat human papillomavirus (HPV) testing or HPV co-testing at one year in patients with *only minor screening abnormalities*

PRIMARY HPV SCREENING - option according to guidelines, **not available in military yet**

HPV VACCINATION – **Gardasil** – encourage use for all patients ages 9-45

REFERRAL INDICATED:

- See **app for all pap smears indicating need for colposcopy**
- Atypical glandular cells – colposcopy +/- endometrial biopsy indicated (age-dependent)
- Atypical endometrial cells – endometrial biopsy +/- colposcopy

Well Woman Examination

Clinical Breast Exam (CBE)

Clinical Breast Exam (CBE)

- No longer recommended as part of screening for **average-risk women**
- Encourage breast self-awareness and seeking medical attention for **abnormal breast findings promptly** (ACOG)
- **Diagnostic CBE is recommended** as part of the initial evaluation in women with breast complaints or abnormalities

ADDITIONAL EVALUATION

- **Ultrasound:** indicated for women < 30 years with new mass
- **Mammogram** (low-dose X-ray):
  - Women with **average** risk of breast cancer begin screening mammography no earlier than 40 years, and no later than 50 years (no family history).
  - Mammograms should then occur every 1-2 years, usually until at least 75 years.
- A **biopsy** is needed to definitively diagnose cancer

Well Woman Examination

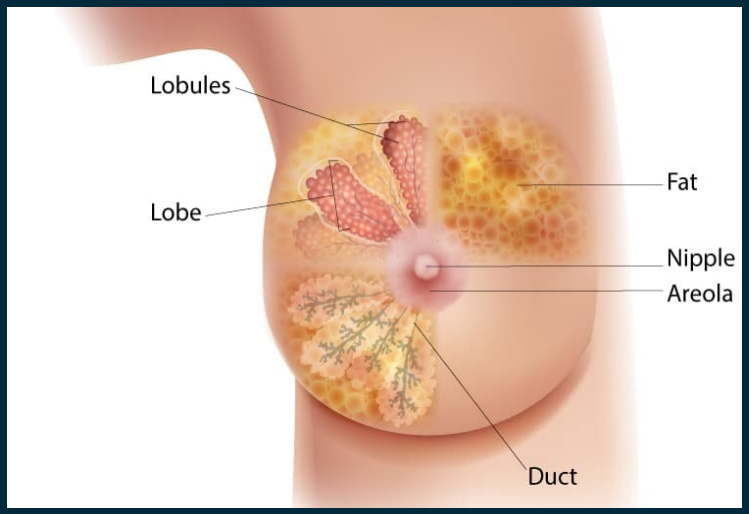
Encourage Breast Self-Awareness

ENCOURAGE BREAST SELF-AWARENESS WITH THE GOAL OF FINDING BREAST CANCER AS EARLY AS POSSIBLE

Patients to alert provider if any of the following changes:

- Lump
- Nipple discharge
- Unilateral swelling
- Skin changes (irritation or dimpling)
- Nipple distortion or changes – including pain, redness, flaking or turning inward

If any of the above noted – patient requires a clinical breast examination



Breast Cancer | Source: *Centers for Disease Control and Prevention via cdc.gov*

Well Woman Examination

Breast History, Findings, and Evaluation

COMMON BREAST SYMPTOMS – MASSES, DISCHARGE, PAIN, SKIN CHANGES, CANCER

HISTORY/PHYSICAL

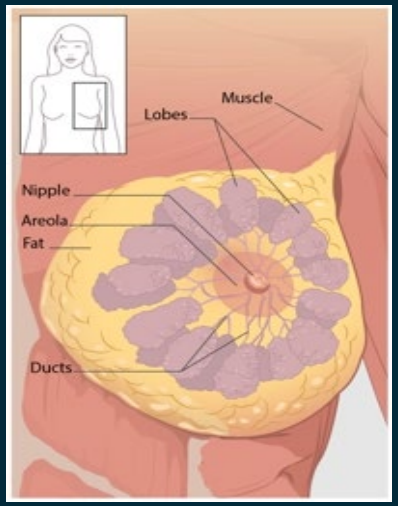
- Symptoms: pain, skin changes, mass characteristics, duration, location, discharge
- Family, reproductive, breastfeeding history
- Evaluate for symmetry, skin changes, lymph nodes
  - Describe mass with size, distance from areola, consistency

FINDINGS

- Mass
- Nipple discharge
  - Benign vs. concern for malignancy
  - Galactorrhea
- Mastalgia

EVALUATION

- Urine pregnancy test, condition specific labs
- Imaging – indicated for mass or concerning discharge
  - < age 30: ultrasound of breast; consider observation 1 cycle to determine if disappears
  - > age 30: diagnostic mammogram



What is Breast Cancer? | Source: *cdc.gov*

Additional Breast Concerns

Treatment and Referrals

TREATMENT

- Breast related symptoms are **common** - masses, discharge, breast pain, skin changes, cancer
- Mass or discharge – **consult specialist**
- **Mastalgia**:
  - Reassurance, well supported bras, avoiding triggers, NSAIDs
  - Consider switching oral contraceptive (OCPs) to continuous use

REFERRAL INDICATED to Breast Health Center/General Surgery:

- **For a mass:**
  - After results of imaging
- **For nipple discharge:**
  - Prior to imaging if high concern for cancer (i.e. family history)
- **For Mastalgia:**
  - If fails conservative treatments

Prior to referral: complete breast exam, determine if mass noted, or concerning discharge symptoms, complete/order imaging

Diagnosis and Management of Benign Breast Disorders | Source : *acog.org*

Well Woman Examination

Mammogram Recommendations

	U.S. Preventive Services Task Force (USPTF)	American Cancer Society	American College of Obstetricians and Gynecologists	American College of Radiology	American College Physicians	American Academy of Family Physicians
Women aged 40 to 49 years with average risk	Individualized choice	40-44: Choice 45-49: annually	Choice, 1-2 years	Yearly	Not REC	Individualized choice
Women aged 50 to 74 years with average risk	1-2 years	50-54: annually >55: 1-2 years	1-2 years	Yearly	1-2 years	1-2 years
Women aged 75 years or older with average risk	Insufficient evidence	Continue if life expectancy > 10 years	Shared Decision making, consider life expectancy	Shared Decision making, consider life expectancy	Shared Decision making, consider life expectancy	Insufficient Evidence

Mammogram Recommendations | Source: *cdc.gov*

Routine Immunizations

Age-Based Recommendations

HPV Vaccine (Human Papilloma Virus) - GARDASIL

- Prevents against nine common types of HPV which cause 90% of cervical cancer and genital warts
- **2- dose or 3- dose series (age-based)**
- **Recommended to all regardless of HPV status (prior infection)**
- **All children and adults aged 9 through 26 years.**
- **Adults aged >26 to 45 years.** Shared clinical decision-making regarding based on risks. Generally recommended to all patients in this range
- **Avoid in pregnancy (live vaccine); okay in breastfeeding**
- Resume series where left off (if missed timing of doses); utilize newer vaccine if prior dose was quadrivalent **(when in doubt, check CDC!)**

Zoster

- **1 dose**; Recommended at age 50

Pneumococcus

- **2 doses**; Recommended at age 65 or sooner for medical conditions (see CDC)

Influenza

- Recommend **annually**

Routine Immunizations

Other Recommended Adult Immunizations

Vaccine	19 – 26 years	27 – 49 years	50– 64 years	>= 65 years
Influenza inactivated (IIV) or **Influenza recombinant** (RIV4)	1 dose annually			
Influenza live, attenuated (LAIV4)	1 dose annually			
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap each pregnancy; 1 des Td/Tdap for wound management (see notes)			
	1 dose Tdap then Td or Tdap booster every 10 years			
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)			
Varicella (VAR)	2 doses (if born in 1980 or later)		2 doses	
Zoster recombinant (RZV)			2 doses	
Human papillomavirus (HPV)	2 or 3 doses depending on age at initial vaccination or condition	27 through 45 years		
Pneumococcal conjugate (PCV13)	1 dose			1 dose
Pneumococcal polysaccharide (PPSV23)	1 or 2 doses depending on vaccine			1 dose
Hepatitis A (HepA)	2 or 3 doses depending on vaccine			
Hepatitis B (HepB)	2 or 3 doses depending on vaccine			
Meningococcal A, C, W, Y	1 or 2 doses depending on indication, see notes for booster recommendations			
Meningococcal B (MenB)	19 through 23 years	1 or 2 doses depending on indication, see notes for booster recommendations		
Haemophilus influenzae type b (HiP)	1 or 3 doses depending on indication			

Immunization Schedule | Source: *CDC.gov*

- Recommended vaccination for adults who meet age requirements, lack documentation of vaccination, or lack evidence of past infection
- Recommended vaccination based on shared clinical decision-making
- Recommended vaccination for adults who meet age requirements, lack documentation of vaccination, or lack evidence of past infection
- No recommendation/ Not applicable

Sexual Health
Screening Questions

A BRIEF SET OF SCREENING QUESTIONS IS ADEQUATE TO DETERMINE WHETHER A PROBLEM EXISTS AND REQUIRES FURTHER INQUIRY:

- Do you have sexual concerns?
- Are you currently having or have you ever had sexual relations?
- If not, when did you last engage in sexual activity?
- If so, with an individual of the same or different sex, or both?
- Have you recently had any new partners or sexual contacts?
- Do you protect yourself from pregnancy and sexually transmitted infections?
- Would you like to be screened for sexually transmitted infections?
- Do you need contraception or preconception counseling?

Sexually Transmitted Infections (STIs)

Sexual Health

What are some **common symptoms** that may present with a sexually transmitted infection such as chlamydia or gonorrhea?

STI Screening Recommendations in Women

Regardless of Sexual Orientation

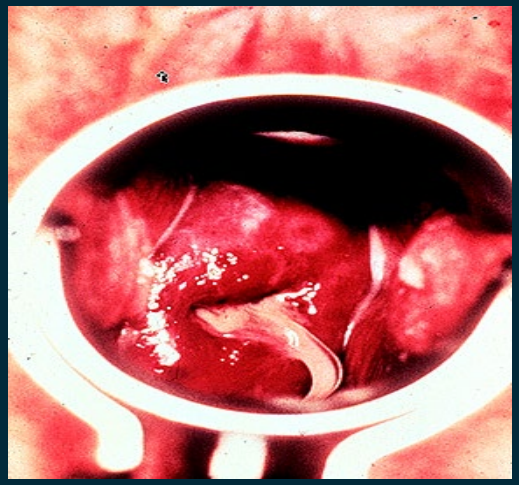
Group	Infection Type	Frequency to Screen	Notes
<25 years	Chlamydia and Gonorrhea	Annually	Screen for syphilis, trichomoniasis, and HBV if at increased risk. Screen for HCV if age >18 years (in areas with HCV positivity > 0.1%).
	HIV	At least once	
>= 25 years	HIV	At least one	
Pregnant	Chlamydia and Gonorrhea	First Trimester, 3rd trimester (if <25 years or an increased risk)	
	Syphilis	First Trimester, 3rd trimester if at high risk	
	HIV	First Trimester, 3rd trimester if at high risk	
	HBV/HCV	First Trimester, HBV repeated at delivery if high risk	
With HIV Infection	Chlamydia and Gonorrhea	Annually	
	Trichomoniasis	Annually	
	Syphilis	Annually	
	HBV	First Visit	
	HCV	First Visit	

Sexually Transmitted Infections

Chlamydia: Clinical Findings and Treatment

PHYSICAL SIGNS/ SYMPTOMS

- Majority of patients asymptomatic
- Most symptoms are non-specific in nature, correlated by clinical syndromes
  - Acute cervicitis – intermenstrual bleeding, post-coital bleeding, changes in vaginal discharge
  - Acute urethritis – dysuria, urinary frequency



Mucopurulent discharge from Chlamydia cervicitis | Source: *uptodate.com*

TREATMENT

- **First line**: Doxycycline 100 mg taken by mouth (PO) twice per day for 7 days
- *OR*
  - Azithromycin 1 g PO as single dose (pregnant patients or unreliable patients)
  - Levofloxacin 500 mg PO daily for 7 days
  - See CDC for other options
- Consider need for concurrent treatment for gonorrhea

Always refer to the most current CDC treatment guidelines for the up-to-date evidence-based prevention, diagnostic and treatment recommendations

Sexually Transmitted Infections

Gonorrhea: Clinical Findings and Treatment

PHYSICAL SIGNS/SYMPTOMS

- Varies – Asymptomatic, cervicitis, vaginal pruritis and/or mucopurulent discharge, intermenstrual bleeding, urethritis
- Dyspareunia and abdominal pain are concerning for pelvic inflammatory disease (PID)
- Diagnosed via NAAT

TREATMENT

- Ceftriaxone
  - Patients weight < 150 kg – Ceftriaxone 500 mg intramuscular (IM) single dose
  - Patients weight ≥ 150 kg – Ceftriaxone 1 g IM single dose
- *Alternatives*
  - Cefoxitin 2 g IM single dose + probenecid 1 g PO single dose
  - Cefixime 800 mg PO single dose (if only oral meds available)
  - Severe cephalosporin allergy
    - Azithromycin 2 g PO single dose + gentamicin 240 mg IM single dose
- Include presumptive treatment for chlamydia

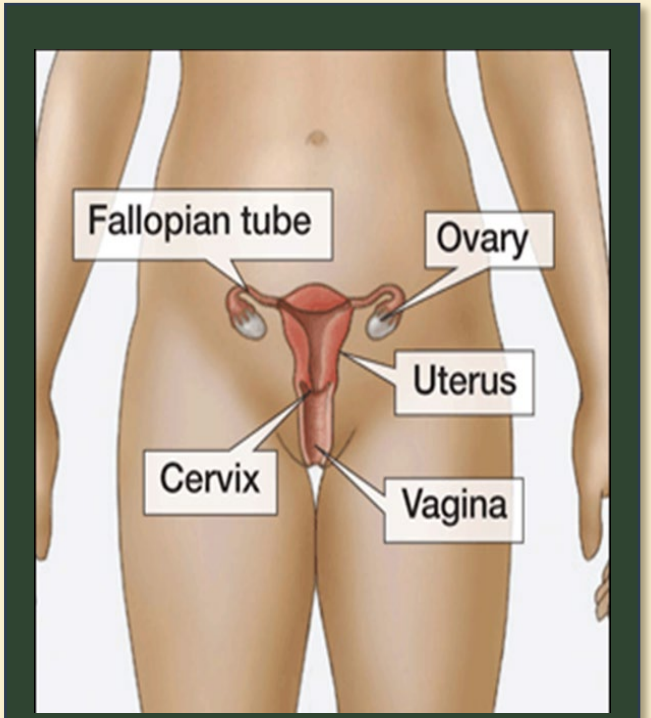
! *Always refer to the most current CDC treatment guidelines for the up-to-date evidence-based prevention, diagnostic and treatment recommendations*

Sexually Transmitted Infections

Pelvic Inflammatory Disease (PID): Clinical Findings

PHYSICAL SIGNS/ SYMPTOMS

- **Symptoms:**
  - Lower abdominal pain (can vary – movement, intercourse, exams)
  - Abnormal uterine bleeding (intermenstrual, post-coital)
- **Exam:**
  - Abdominal tenderness in lower quadrants, bilateral or unilateral
  - Acute cervical motion, adnexal uterine tenderness on bimanual pelvic exam
  - Rebound tenderness, fever (severe PID)
- **Laboratory evaluation:**
  - Possible leukocytosis
  - C-reactive protein (CRP) and erythrocyte sedimentation rate (ESR) not necessarily beneficial
- **Presumptive diagnosis** of PID based on cervical motion tenderness and history
- Do not delay initiation of empiric treatment while awaiting laboratory results



Vulvar anatomy | *Source: cancer.gov*

Sexually Transmitted Infections

Pelvic Inflammatory Disease (PID): Treatment

TREATMENT

- **Ceftriaxone + doxycycline + metronidazole**
  - Ceftriaxone is preferred cephalosporin
    - Patients weight < 150 kg – Ceftriaxone 500 mg IM single dose
    - Patients weight ≥ 150 kg – Ceftriaxone 1 g IM single dose
  - Doxycycline 100 mg PO twice daily for 14 days
  - Metronidazole 500 mg PO twice daily for 14 days
- **Alternatives**
  - Alternative cephalosporin is cefoxitin 2 g IM single dose + probenecid 1 g PO single dose
  - Alternative to doxycycline is azithromycin
    - 500 mg daily for 1 to 2 days, then 250 mg PO for 12 to 13 days (total 14 days), OR
    - 1 g once per week for two weeks

! *Advise patients to **refrain from alcohol use while taking metronidazole**. Possible symptoms include: Abdominal cramps, nausea, vomiting, headaches, and flushing have been reported with oral and injectable metronidazole and concomitant alcohol consumption (disulfiram-like reactions).*

Sexually Transmitted Infections

Human Papillomavirus (HPV): Clinical Findings and Treatment

PHYSICAL SIGNS/ SYMPTOMS

- Cutaneous: plantar or common warts
- Mucosal
  - Condyloma acuminata (benign anogenital warts)
    - HPV subtypes 6 and 11
  - Cervical Intraepithelial lesions and carcinomas
    - ~15 subtypes; HPV 16 and 18 most common and of greatest concern)

Cervical cancer| Source: *CDC.gov*

TREATMENT

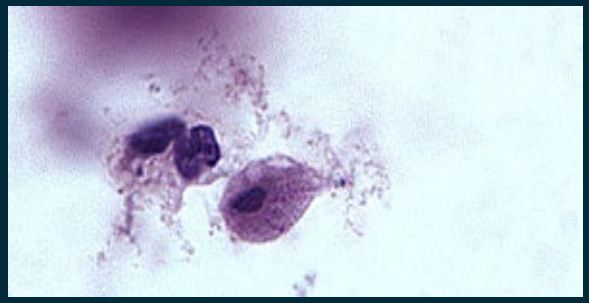
- Cutaneous warts: cryotherapy and topical salicylic acid
- Anogenital warts: Podofilox, trichloroacetic acid (TCA), surgical excision
- Vulvar intraepithelial lesions: excision (first line) or ablation

Sexually Transmitted Infections

Trichomoniasis: Clinical Findings and Treatment

PHYSICAL SIGNS/SYMPTOMS

- Green-yellow, frothy, malodorous, thin discharge
- Symptoms of dysuria, pruritis, dyspareunia, urinary frequency, low abdominal pain
- Exam:
  - Punctate hemorrhages on vagina and cervix (i.e., “strawberry cervix”)
  - Vaginal pH > 4.5
  - Microscopy: Presence of motile trichomonads (diagnostic)



Trichomonas vaginalis | Source: *CDC.gov*

TREATMENT

- Metronidazole 500 mg orally 2x/day for 7 days
- *Alternatives*
  - Tinidazole 2 g single oral dose
  - Secnidazole

Sexually Transmitted Infections

Results that Prompt Referral to Specialty Care

RECURRENT SEXUALLY TRANSMITTED INFECTION is usually due to non-compliance with therapy, persistent high-risk behavior, reinfection, or rarely a resistant strain.

Necessary Counseling

- Safe sex practices – all patients
- Barriers to safe sex
- Partner treatment

SYPHILIS: Determine if primary, secondary, tertiary and refer to infectious disease

- Test for human immunodeficiency virus (HIV)
- Treat as indicated per CDC guidelines (https://www.cdc.gov/std/treatment-guidelines/default.htm)

REFERRAL INDICATED:

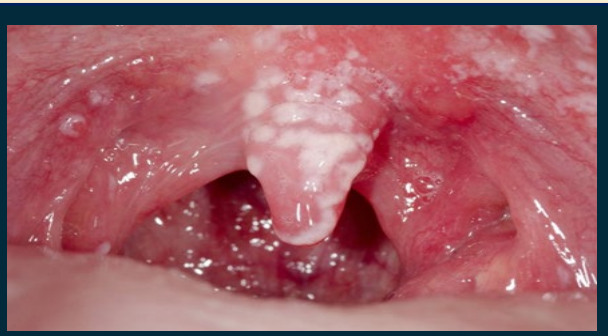
- If practicing safe sex, complying with treatment, yet still infected
- Concern for resistant strain
- HIV or syphilis – usually infection disease referral

Sexual Health

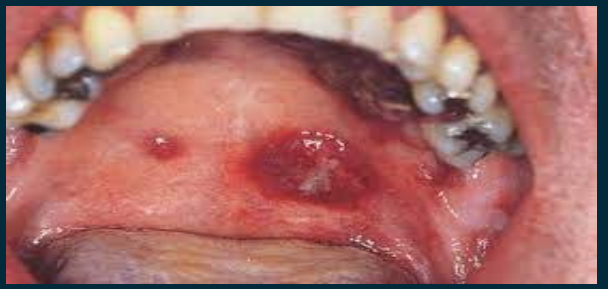
Human Immunodeficiency Virus (HIV/AIDS): Clinical Findings

PHYSICAL SIGNS/ SYMPTOMS

- **Acute** retroviral syndrome
- Vague, **nonspecific** symptoms
- Fever, lymphadenopathy, myalgias/arthralgias, sore throat, rash, diarrhea, headache, weight loss
- Presence of **mucocutaneous ulcers** significantly raises suspicion of HIV infection
- **Monospot** for Epstein-Barr virus (EBV) is occasionally positive with HIV
- Opportunistic infections and infections with **central nervous system involvement** should always be investigated for HIV



Oral Candidiasis | nhs.uk



Mucocutaneous ulcers in HIV | *med.upenn.edu*

Sexual Health

Human Immunodeficiency Virus (HIV/AIDS): Prevention

PREVENTION

- Use of **barrier methods** (condoms)
- **Preexposure prophylaxis (PrEP)** is a single daily pill comprised of 300 mg of tenofovir disoproxil fumarate (TDF) and 200 mg of emtricitabine (FTC) (brand name Truvada)
  - Recommended for HIV negative adults at **very high risk** for getting HIV from sex or injection drug use
- Ensure the patient is **HIV-negative**
  - **Test for HIV** (Rapid test is acceptable. Recommend a negative HIV test within the 7 days preceding PrEP start date.)
- Screen for **recent symptoms** of acute HIV infection
- Screen for **vaginal/urethral, pharyngeal** and **rectal gonorrhea** and **chlamydia**
- Screen for **syphilis**
- Screen for **serum creatinine**
- Screen for **pregnancy**, **Hepatitis B Surface Antigen** and **Hepatitis C Antibody**

Mental Health Considerations

Common Mental Health Disorders and Stress Management Techniques

COMMON MENTAL HEALTH DISORDERS

- **Anxiety**
- **Depression**
- **Premenstrual- Dysphoric Disorder**
- **Post-traumatic Stress Disorder (PTSD)**
- **Eating Disorders**

COMMON STRESS MANAGEMENT TECHNIQUES

- **Relaxation** techniques
- Working with a therapist to boost **coping skills** (Military OneSource, Fleet and Family, Military Family Life Counselors, or Mental Health referral for counseling)
- Use of **phone applications** like (Calm, Headspace, just examples of the many available, often free)
- **Exercise**
- **Antidepressants** (Selective Serotonin Reuptake Inhibitor (SSRIs) or others)

More information on mental health will be shared later in the Seminar

Questions & Answer Session

References

1. ACOG Clinical – Diagnosis and Management of Benign Breast Disorders (Link)
2. ACOG: Long-Acting Reversible Contraception: Implants and Intrauterine Devices (Link)
3. ACOG Practice Bulletin 186 – Long Acting Reversible Contraception
4. CDC Reproductive Health – Contraception (Link)
5. CDC Reproductive Health – Contraception Summary (Link)
6. Darney, Philip; *Etonogestrel Contraceptive Implant* (Link)
7. Madden, Tessa; *Intrauterine Contraception: Candidates and Device Selection* (Link)

Women's Health Seminar

SESSION 2: UNDERSTANDING COMMON WOMEN'S HEALTH CONCERNS

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Learning Objectives

LEARNING OBJECTIVES

- Review key elements of vaginal care
- Overview menstrual cycle and management
- Discuss contraception
- Overview of pelvic pain and pelvic masses
- Discuss infertility diagnosis and evaluation
- Overview of early pregnancy
- Review medical evacuation for women's health - related concerns

_____ Vaginitis, Vaginal Care and _____ Hygiene

Vaginal Care and Hygiene

Best Practices

What Is Normal?

- Normal vaginal discharge is **clear-white and odorless**
- It will change slightly throughout the menstrual cycle
- Change in color, odor, amount, or consistency from baseline are signs of **abnormal discharge**

How to Care for the Vulva and Vagina

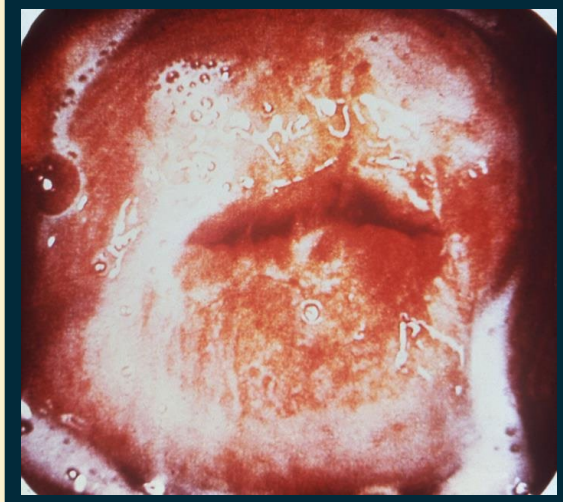
- **Avoid irritants** that may alter the **acidic environment** and the balance of healthy bacteria – no douching, no special "vaginal soaps," no soap into the vagina
- No medical or hygienic reason to **perform pubic hair removal**
  - Risk for **ingrown hairs** and **pain**
- Wash the **outer genital area** daily with mild soap and water
- **Wash your hands** before and after changing menstrual product
- Routinely clean sex toys and do not share toys

Vaginitis
Evaluation

History
- Associated symptoms: Fever, chills, dysuria, abdominal pain, pelvic pain
- Past history of infections
- Last period, current contraceptive use, STI risk factors

Physical Exam
- Speculum exam: Cervix, discharge, bleeding
- Bimanual exam: Evaluate for cervical motion tenderness

Laboratory Evaluation
As available in your institution
- STI screening (chlamydia, gonorrhea, herpes, syphilis, and trichomonas)
- Microscopy (if qualified)
- If not available – can treat based on presentation (see next slide)



Vaginal Discharge | phil.cdc.gov/

Vaginitis

Infection or inflammation of Vaginal Issue Associated with Irritative Symptoms of Burning, Itching, Odor, Pain, or Discharge

DIFFERENTIAL DIAGNOSIS

- Physiologic – clear, white, creamy thin
- Bacterial vaginosis – grey, green, thin, fishy odor
- Vulvovaginal candidiasis – thick, white, pruritic
- Trichomonas – varies, post coital bleeding
- Dermatitis

DIAGNOSIS

- Microscopy (wet mount, KOH), nucleic acid amplification test (NAAT), pH testing

TREATMENT

- **Bacterial Vaginosis:** Metronidazole 500 mg BID for 7 days
- **Vulvovaginal candidiasis:** Oral – fluconazole 150 mg once
- **Trichomonas**: Metronidazole 500 mg BID for 7 days
- List is not all inclusive – see CDC.gov for other treatment options

REFERRAL INDICATED: Recurrent vaginitis > 2 episodes; 1 recurrence of Trichomonas
Concern for poor hygiene, medication compliance, immunosuppression, complicated cases

Reference: ACOG Practice Bulletin 215 – Vaginitis in Non-pregnant Patients

Vaginitis

Signs, Symptoms, and Treatment

Infection	Sign/Symptom	Diagnosis	Treatment
Candidiasis	Vulvar pruritis, vaginal soreness, dyspareunia Erythema of vaginal mucosa White, thick, clumpy, “cottage cheese-like” discharge adherent to vaginal sidewalls Normal-appearing cervix	Clinical – symptoms and exam Microscopy - Hyphae/ buds with potassium hydroxide (KOH) Vaginal pH 4.0- 4.5	Initial: Fluconazole (Diflucan) 150 mg orally x 1 Alternative: Clotrimazole (topical) Miconazole
Bacterial vaginosis	Thin, grayish-white discharge Complaint of malodorous discharge	Vaginal pH >4.5 Microscopy - Clue cells on saline wet mount Positive whiff-amine test, defined as the presence of a fishy odor when a drop of 10 percent KOH is added to a sample of vaginal discharge	Metronidazole 500 mg orally 2x/day for 7 days or Metronidazole gel 0.75% one 5 gm applicator intravaginally, 1x/day for 5 days OR Clindamycin cream 2%, one 5 gm applicator intravaginally, at bedtime for 7 days

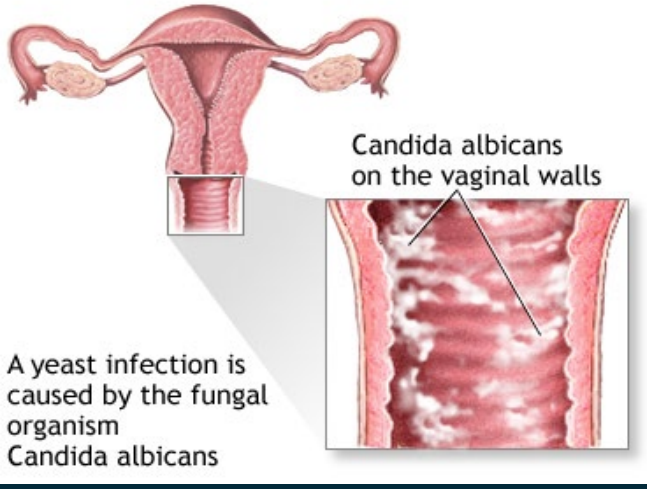
Vaginitis

Signs, Symptoms, and Treatment

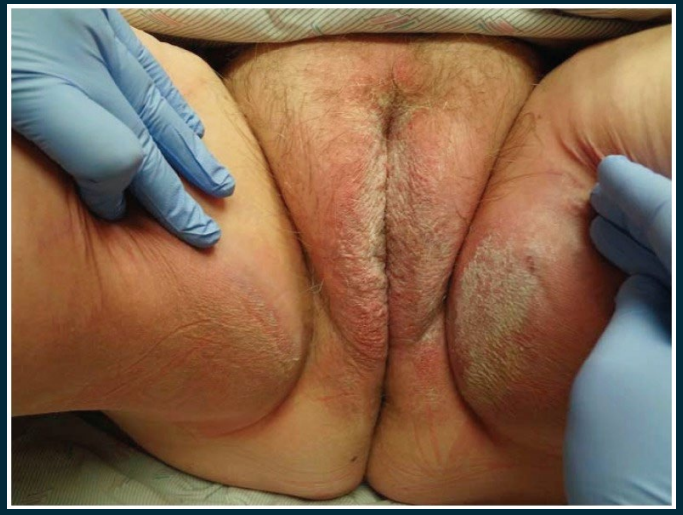
Infection	Sign/Symptom	Diagnosis	Treatment
Trichomonas **(protozoan Trichomonas vaginalis)**	~10-17% Vulvar pruritis, burning, dysuria, lower abdominal pain, dyspareunia Asymptomatic with change in discharge	Clinical – symptoms and exam - Malodorous discharge, punctate hemorrhages on vaginal mucosa/cervix (strawberry cervix) Microscopy – Mobile trichomonads NAAT Positive rapid antigen test	Metronidazole 500 mg BID for 7 days Other options: - Tinidazole 2 gm PO daily x 7 d. - Secnidazole 2 gm PO x1
	Erythema of vulvar and vaginal mucosa Malodorous thin, purulent vaginal discharge (green-yellow frothy discharge in <30%)		
Dermatitis	Mild to severe erythema	Clinical	Low-to-medium potency corticosteroids or high-potency for severe
	Pruritis with excoriation		

Vaginitis

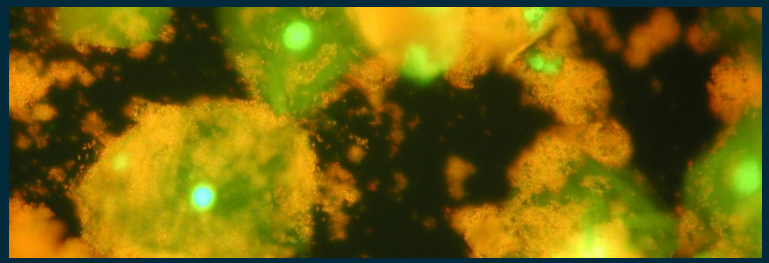
Clinical Findings



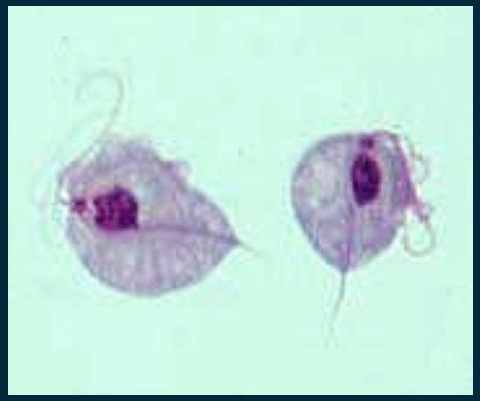
Yeast Infection| Source: *medlineplus.gov*



Contact vulvar dermatitis | Source: *www.ncbi.nlm.nih.gov*



Bacterial Vaginosis | Source: *CDC.gov*



Trichomonas | Source: *CDC.gov*

Menstrual Cycle, Management, Workup for Abnormal Uterine Bleeding

Menstrual Cycle
Overview

Menstrual Cycle

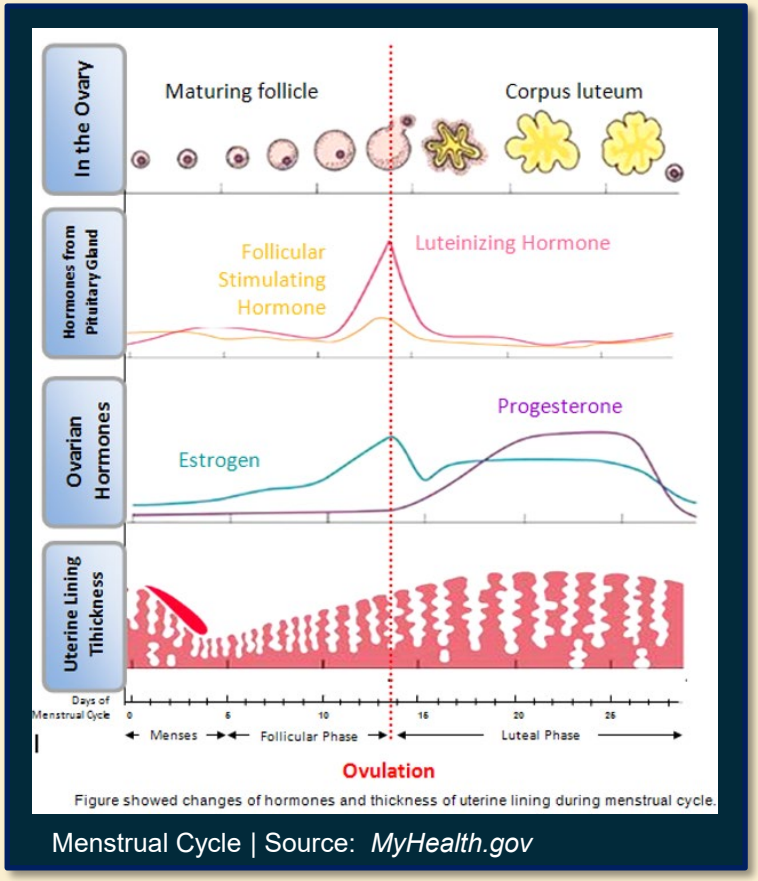
- Counted from day 1 of bleeding in one cycle to the day of bleeding in next cycle

Normal Range

- Length of bleed: 3–7 days
- Cycle Length: 21–35 days
- Heaviness: subjective

What are the patient's desires for menstrual management?

- Bleeding pattern goal - Amenorrhea vs monthly or every 3 months?
- Pain – is it an issue? Need to decrease?
- Feasibility of use/acceptability of method (i.e., can the patient take a pill daily, LARC preferred)



Menstrual Cycle | Source: *MyHealth.gov*

Optimizing Menstrual Cycle

Menstrual Management

LEVONORGESTREL IUD

(Mirena ® FDA approved for HMB) – Progesterone only

- Approved for **8 years contraceptive**, **5 years for AUB management**
- By **6 months 80-90%** of women have amenorrhea or lighter menses by thinning endometrial lining
- Similar effects seen with **Kyleena IUD**

COMBINED HORMONAL CONTRACEPTION (CHC)

Daily tablet

- Mainstay of treatment used to **regulate menstrual cycles** (frequency/amount)
- Can be used **monthly** or **extended suppression** (3-month formulations)
- Typically **lightens** and **shortens** duration of menses

MEDROXYPROGESTERONE ACETATE

(Depo-provera ®) – IMq 10-13 weeks

- High rates of **amenorrhea**
- Not recommend for women who desire near future fertility as this method has delayed return to fertility

Optimizing Menstrual Cycle

Menstrual Management Continued

ETONORGESTREL IMPLANT (NEXPLANON®) – Subdermal device

- Effective for **4-5 years**
- Variable rates of **amenorrhea** vs. **unscheduled bleeding**
- Bleeding patterns are **not predictable** prior to use
- Counsel patients on **irregularity of bleeding**

TRANEXAMIC ACID (Lysteda®) – oral non-hormonal formulation

- Excellent for women with contra-indications for hormones or declines hormonal medication
- Contraindicated in prior history of venous thromboembolism and with CHC use

NSAIDs – Given TID for 3-5 day

- Down regulates prostaglandin production
- Nice alternative or addition to contraception

NOT RECOMMENDED – Copper IUD, progestin only pill (POP)

Defining Abnormal Uterine Bleeding

Irregular or Heavy Menstrual Bleeding

CRITERIA

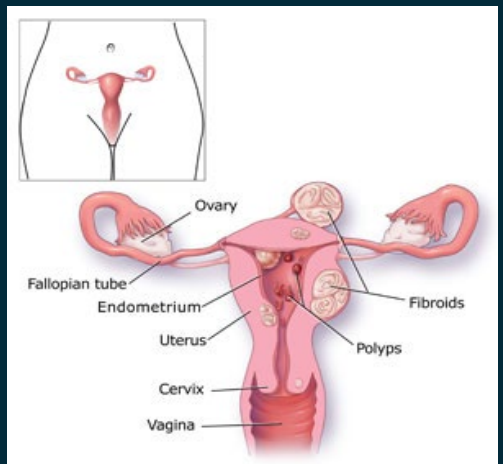
- Symptoms beyond the normal menstrual cycle; interfere with quality of life

DIFFERENTIAL DIAGNOSIS

- Classification of the causes of abnormal uterine bleeding in non-pregnant women pf reproductive age (PALM-COEIN)

LABS

- Urine pregnancy test (UPT), complete blood count (CBC), Iron panel, gonorrhea and chlamydia screening testing (GC/CT) testing, Trichomonas, thyroid stimulating hormone (TSH)



Heavy Menstrual Bleeding| *Source: CDC,* U.S Department of Health and Human Services

ANEMIA

- Etiology: Iron deficiency, nutritional, acute or chronic loss, production or consumption
- Symptoms dictate routine or emergency referral

REFERRAL INDICATED: After workup initiation, considered non-gynecologic etiologies, biopsy indicated , > 45 years without risk factors, < 45 years with risk factors, HONDA: Hypertension, obesity, nulliparity, diabetes, anovulation

Abnormal Uterine Bleeding

Treatment for Irregular or Heavy Menstrual Bleeding

INITIAL TREATMENT

- Trial of nonsteroidal anti-inflammatory drugs (NSAIDs)
- Trial of tranexamic acid (TXA) (may be limited based on your pharmacy)
- Initiation of contraception for menstrual control
- Rule out concerning causes

CONTRACEPTION RELATED

- Expectation management with long-acting reversible contraception (LARCs) prior to placement
- LARC in place < 3 months – Counseling
- LARC in place > 3 months – Consider specialist referral
    - No contraindications to estrogens
        - Combined hormonal contraceptive (CHC) or estrogen
    - With or without contraindications to estrogens
        - NSAID course with menses or TXA

REFERRAL INDICATED: If concerning causes are ruled out and trialed one of the above treatments

Urinary Tract Infections (UTIs)

Urinary Tract Infection

Clinical Findings and Evaluation

ACUTE SIMPLE CYSTITIS

Definition: Dysuria, urinary frequency, urinary urgency, suprapubic pain, and/or hematuria localized to the bladder; without signs or symptoms suggesting an upper tract or systemic infection

Evaluation:

- 1 of symptoms makes diagnosis likely; 2 or more increases likelihood
- Urinalysis and urine culture
- Evaluation for pyelonephritis
- Consider pelvic examination for vaginitis symptoms

ACUTE COMPLICATED UTI

Definition: Signs or symptoms that suggest extension of infection beyond the bladder with fever (>99.9°F/37.7°C); chills, rigors, significant fatigue. malaise or other features of systemic illness; flank pain; costovertebral angle tenderness

Common Infections

Simple Cystitis: Treatment

Suspected cystitis?

Features concerning for acute complicated UTI?

YES

Manage Acute Complicated UTI (Discuss with Physician Supervisor if IDC or with SMO or Family Medicine for non-specialty trained GMOs)

NO

Are there any risk factors for an MDR gram-negative infection?
(MDR isolate, inpatient stay, use of broad spectrum antibiotics within last 3 months)

YES

Obtain urine culture and susceptibility

1) Consider deferring treatment until confirmed sensitivities if reason to avoid below
2) OR treat with nitrofurantoin 100 mg BID for 5 days or fosfomycin 3 g PO

NO

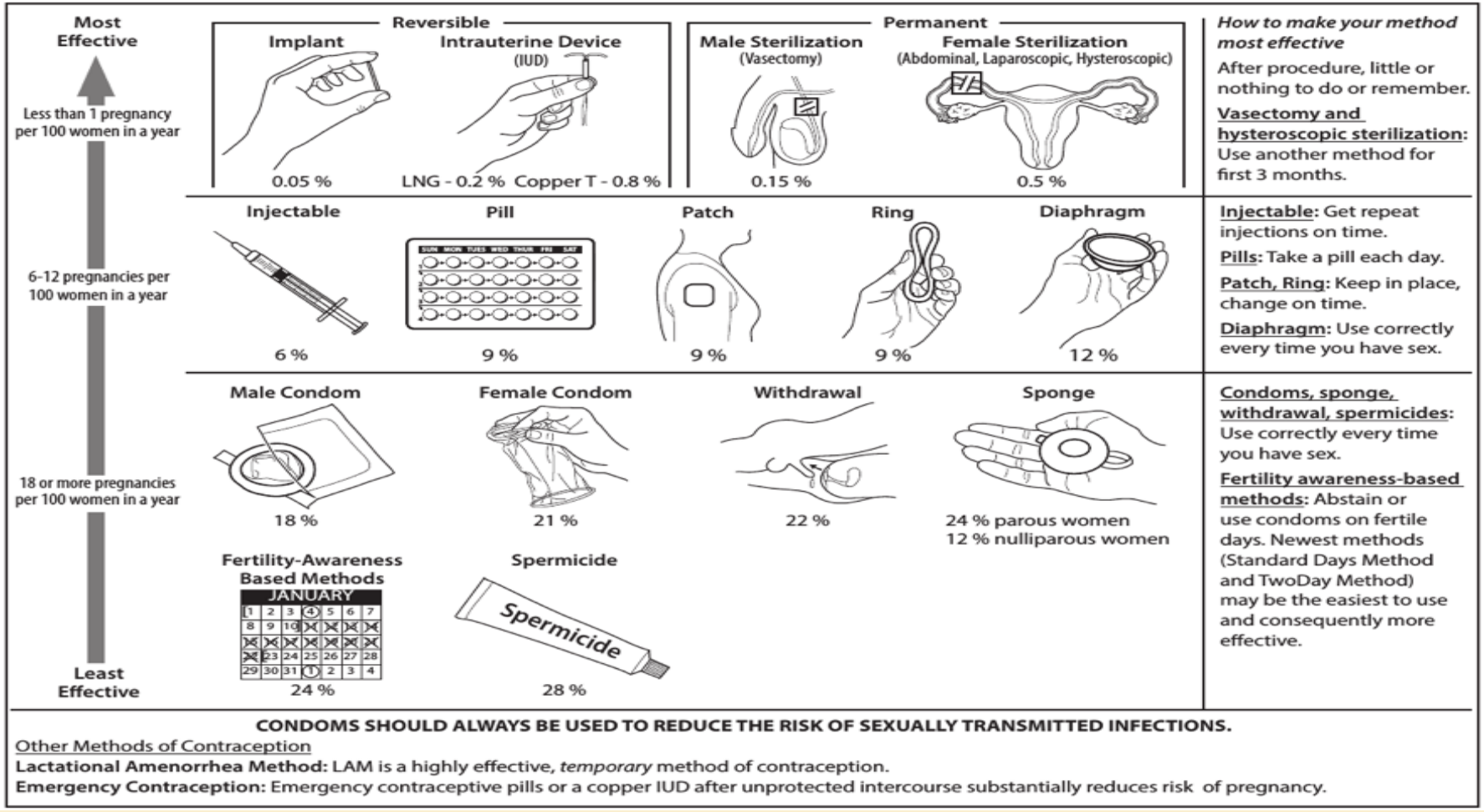
Antibiotic therapy can generally be administered empirically without obtaining a urine culture

1) Nitrofurantoin 100 mg BID for 5 days; TMP-SMX 160/800 mg PO BID for 3 days; Trimethoprim 100 mg BID for 3 days
2) Other regimens exist if concern for reasons to avoid beta-lactam, fluroquinolones or any of the above.

Contraception

Contraception Efficacy

Overview



Contraception Efficacy | *Source: cdc.gov*

Counseling on Contraception

Helpful Phone Applications for Patients

US MEC and US SPR App | *Source: Contraception App via cdc.gov*

CDC Contraception App

Decide + Be Ready Mobile App | *Source: Military Health Systems via Health.mil*

Scan the quick response (QR) code here to download the **Decide + Be Ready mobile app.**

Contraception Eligibility

Medical Eligibility Criteria (MEC)

Medical Eligibility Criteria: Contraception

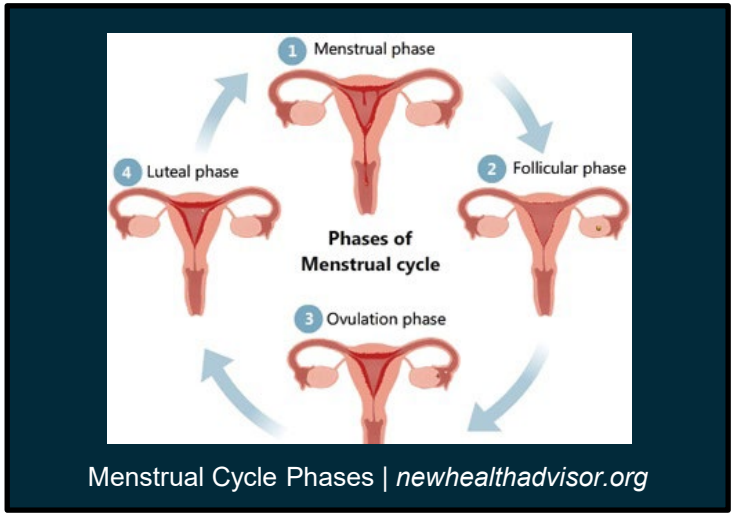
- **1** = **No restriction** for the use of the contraceptive method
- **2** = Advantages of using the method **generally outweigh the theoretical or proven risks**
- **3** = Theoretical or proven **risks usually outweigh the advantages** of using the method
- **4** = **Unacceptable health risk** if the contraceptive method is used

US MEC and US SPR App | *Source: Contraception App via cdc.gov*

Contraception

Benefits Other Than Pregnancy Prevention

- ✓ **Lighter menses:** use of progesterone can thin and protect uterine lining
- ✓ **Suppresses menstrual cycle:** Increase interval in between menses or decrease bleeding
- ✓ **Suppress endometriosis**: decreased associated pain and bleeding episodes
- ✓ **Treat premenstrual and premenstrual (PMS) dysphoric disorder (PMDD)**: improved mood symptoms by suppressing ovulation
- ✓ **Assist in reduction of androgenic symptoms**: reduces male pattern hair growth and acne



Menstrual Cycle Phases | *newhealthadvisor.org*

Contraception Timing

Contraceptive Timing by Method

Method	Patient Use	Access to Contraceptive Method
Pills	Daily	Prescription via PCM
Patch	Weekly	
Ring	Monthly	
Depo Provera®	Q3 months	
NEXPLANON®	Every 3-5 years; FDA evidence vs efficacy	Can be provided by PCM, some may require specialist referral for placement
Levonorgestrel (LNG) releasing IUD	Every 3-8 years; depending on type of device; FDA evidence vs efficacy	
Paragard®, Copper IUD	Every 10-12 years; FDA evidence vs efficacy	

Contraindications to CHCs

Short Acting Reversible Contraception (SARC)

SARC CONTRAINDICATIONS

+ Uncontrolled **hypertension (>160/100)**
+ **Migraine** with localizing neurological signs **(aura)**
+ **Smoking** > 15 or more cigarettes/day in women > 35 < 21 days postpartum
+ Multiple risk factors for **arterial cardiovascular disease**
+ Complicated **valvular heart disease** with pulmonary hypertension
+ Peripartum **cardiomyopathy**
+ **SLE** with positive or unknown anti-phospholipids
+ **Breast cancer** (current)
+ **Cerebrovascular** or **coronary artery disease**
+ **Diabetes** with vascular disease
+ **Severe cirrhosis** or **acute viral hepatitis**

Tool to Assess Contraindication to Estrogens

Short Acting Reversible Contraception

QUESTIONS FOR ASSESSING CONTRAINDICATION TO ESTROGENS

1. Are you currently **breastfeeding a baby less than 6 months** of age?
2. Do you **smoke cigarettes** AND are you more than **35 years of age**?
3. Have you ever been told you have **breast cancer**?
4. Have you ever had a **stroke**, **blood clot in your legs or lungs**, or **heart attack**?
5. Do you have repeated **severe headaches**, often on one side, and/or pulsating, causing nausea, and which are made worse by light, noise, or movement?
6. Do you regularly take any pills for **tuberculosis (TB)** or **seizures (fits)**?
7. Have you **given birth in the last 6 weeks**?
8. Do you have **gall bladder disease** or **serious liver disease** or **jaundice** (yellow skin or eyes)?
9. Have you ever been told you have **high blood pressure**?
10. Have you ever been told you have **diabetes** (high sugar in your blood)?
11. Do you have 2 or more conditions that could increase your chances of a **heart attack or stroke,** such as **smoking**, **obesity**, or **diabetes**?
12. Have you ever been told that you have a **rheumatic disease such as lupus**?

Combined Hormonal Contraception (CHC)

Short Acting Reversible Contraception

CHC OVERVIEW

Types:
- Combination of estrogen and progestin
- Ethinyl estradiol (EE) doses (35, 30, 20, 10mcg)
- Monophasic or variety of multiphasic – Monophasic recommended

Mechanism of Action:
- Inhibition of the midcycle luteinizing hormone surge thereby suppresses ovulation, also suppresses folliculogenesis

Effectiveness:
- Perfect use 99%, Typical use 91%

Dosing:
- Daily

Indications/Uses:
- Dysmenorrhea, heavy menstrual bleeding, premenstrual syndrome or premenstrual dysmorphic disorder, hirsutism, menopausal symptoms (different types)

Benefits:
- Less acne and hirsutism, menstrual regularity, rapid fertility return, lower lifetime risks endometrial, ovarian, and colorectal cancer

Risks: DON'T USE IF CONTRAINDICATION TO ESTROGEN
Stroke, pulmonary embolism, MI, retinal vein thrombosis, thrombophlebitis

Transdermal Contraceptive Patches

Short Acting Reversible Contraception

OVERVIEW OF TRANSDERMAL CONTRACEPTIVE PATCHES

Types:

- Norelgestromin 150mcg & Ethinyl Estradiol 20mcg (Xulane)
- Levonorgestrel 120mcg & Ethinyl Estrdiol 30mcg (Twirla)

Mechanism of Action:

- Suppress ovulation; increase cervical mucus viscosity; endometrial thinning
- Bypass gastrointestinal (GI)

Effectiveness:

- Perfect use 99%
- Typical use 91%

Dosing: Weekly replacement of patch

Indications/Uses: Contraception mostly, some dysmenorrhea, heavy menstrual bleeding

Benefits: Convenient, rapidly reversible, reaches therapeutic contraceptive levels rapidly, peaking 48 hours

Risks: DON'T USE IF CONTRAINDICATION TO ESTROGEN
Stroke, pulmonary embolism, MI, retinal vein thrombosis, thrombophlebitis
Side effects: Breast symptoms, headaches, nausea, skin changes at site

Vaginal Rings

Short Acting Reversible Contraception

VAGINAL RING OVERVIEW

Types:

- **NuvaRing®:** Vinyl Polymer Ring – Ethinyl Estradiol 15mcg and Etonogestrel 120mcg
- **Annovera®:** Silicone Ring - Ethinyl Estradiol 13mcg and Segesterone Acetate 150mcg

Mechanism of Action:

- Suppresses ovulation, increases cervical mucus viscosity, thins endometrial thinning

Effectiveness: Perfect use **99%,** typical use 91%

Dosing:

- **NuvaRing®:** 21 days, 7 days without, then insert new ring
- **Annovera®:** 21 days, 7, clean, then reinsert same ring for next 21 days, up to 13 cycles

Indications/Uses: Contraception mostly, some dysmenorrhea, heavy menstrual bleeding

Benefits:

Less estrogenic effects on hemostasis and lipids

- Patient placement: NuvaRing® can be removed for 3 hours and reinserted in a 24-hour period; Annovera® can be only removed for 2 hours

Risks: DON'T USE IF CONTRAINDICATION TO ESTROGEN

Stroke, pulmonary embolism, MI, retinal vein thrombosis, thrombophlebitis

Side effects: Headaches, vaginal discomfort, breast tenderness, nausea, decreased libido

Progestin Only Pills

Short Acting Reversible Contraception

OVERVIEW OF PROGESTIN ONLY PILLS

- **Types:**
  - Norethindrone; Progestin only, “Mini pill”
- **Mechanism of Action:**
  - Inhibits midcycle luteinizing hormone surge, inconsistently suppresses ovulation, thickens cervical mucus, thins endometrium
- **Effectiveness:** Perfect use 99%; typical use 91%
- **Dosing:** Daily; Do not exceed 3 hours from scheduled dose (ineffective!)
- **Indications/Uses:** Contraception mostly, some dysmenorrhea, heavy menstrual bleeding
- **Benefits:** Rapid return to fertility when discontinued; Safe for breastfeeding; protection from endometrial cancer, no estrogen component

Risks/Contraindications: Ischemic heart disease or stroke; SLE with positive anti-phospholipid ab; active breast cancer; liver cirrhosis, liver masses; bariatric surgery; UNRELIABLE PILL TAKER
Side effects: Unpredictable bleeding pattern, headaches, nausea, breast tenderness

Injectable - Depo Provera®

Intermediate Acting Reversible Contraception

VAGINAL RING OVERVIEW

Types:

- Depo Provera® : 150mg of depot medroxyprogesterone acetate (DMPA) IM in gluteal or deltoid muscle
- Depo subQ Provera 104 - 104mg of DMPA subcutaneous injection in thigh or abdomen

Mechanism of Action: Prevents ovulation, Suppresses follicle-stimulating hormone (FSH) and luteinizing hormone (LH), Thickens cervical mucus, leads to endometrial atrophy

Effectiveness: Perfect use >99%; typical use 94%

Dosing: Injection every 13 weeks (+ 14 days)

Indications/Uses: contraindications to estrogen containing contraceptives or lower efficacy with E containing contraceptives, reduces bleeding associated with fibroids

Benefits: Does not affect breast milk supply, 40-50% have amenorrhea after 1 year, decreased risk for endometrial and cervical cancer, minimal drug interactions

Risks: Unpredictable bleeding, increased interval to return to fertility, FDA black box “reversible bone mineral density loss”, mood changes, increased appetite, weight gain (2-5#/year)
Contraindicatons: Active thrombophlebitis, history of VTE, cerebral vascular disease, known/suspected breast malignancy, liver disease, undiagnosed vaginal bleeding

Long Acting Reversible Contraception (LARC)

Background

LARC OVERVIEW

All LARCs must be placed by a healthcare provider who has been trained in placement of that form of contraception.

Types:

- Copper IUD (intrauterine device) – **Paragard ®** – No hormones
- Hormonal IUD (intrauterine device) – Progesterone only hormonal
  - Levonorgestrel IUDs
    - **Mirena®:** 52mg Levonorgestrel, releases 20 mcg/day
      - >99% effective; FDA approved for 7 years, evidence for 8 years
    - **Liletta®:** 52 mg Levonorgestrel, releases 18.6 mcg/day
      - >99% effective; FDA approved for 6 years
    - **Kyleena®:** 19.5mg Levonorgestrel, 17.5mcg/day
      - 99.69% effective; FDA approved for 5 years
    - **Skyla®:** 13.5 mg Levonorgestrel, 14 mcg/day
      - 99.67% effective; FDA approved for 3 years
- Subdermal contraceptive device - **NEXPLANON®:** 68 mg etonorgestrel,> 99% effective; FDA approved 3 years, evidence suggests 5 years

Copper Intrauterine Device (IUD) - Paragard®

Long Acting Reversible Contraception

COPPER IUD

Types:

Copper wire coiled around T shaped plastic frame

Mechanism of Action:

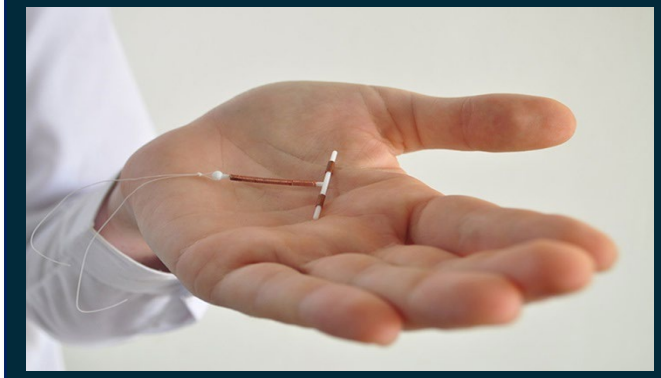
Prevents fertilization through the inhibition of sperm migration and viability

Effectiveness: Perfect use > 99%

Dosing: replaced by 10 years (FDA), 12 years (evidence for efficacy)

Indications/Uses: Contraception with avoidance of exogenous hormones; emergency contraception; Up to 5 days after unprotected intercourse

Benefits: non-hormonal, no medication interactions, does not affect breast milk supply



Copper Intrauterine Device | *Source: Military Health Systems via Health.mil*

- **Contraindications:** Wilson's Disease or copper allergy; uterine anomalies (known), active PID, known or suspected pregnancy, unexplained vaginal bleeding
- **Side effects:** More painful and heavier menses

Levonorgestrel Intrauterine Device (IUD)s

Long Acting Reversible Contraception

LARC OVERVIEW

Types:

- Progesterone only hormonal IUD

Mechanism of Action:

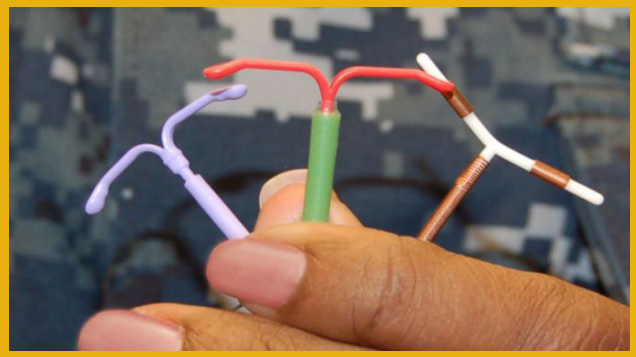
- Prevents fertilization; increases cervical mucous, can prevent ovulation

Effectiveness: Perfect use > 99%

Dosing: year of replacement depends on device – see other slide

Indications/Uses: reduction in menstrual amount thereby improved anemia, less dysmenorrhea, treatment option for pain a/w endometriosis

Benefits: reduced menstrual bleeding, fewer systemic side effects than other contraceptives, does not affect breast milk supply



IUDs | Source: *Navy and Marine Corps Public Health Center*

Contraindications: active breast cancer or liver disease or PID, known or suspected pregnancy, unexplained vaginal bleeding

Etonogestrel Implant - NEXPLANON®

Long Acting Reversible Contraception

NEXPLANON®

Types:

68mg etonogestrel surrounded by an ethylene vinyl acetate copolymer skin

Mechanism of Action:

Suppresses ovulation

Effectiveness: 99.95%

Dosing: Device replacement every 3 years per FDA, evidence suggests effective to 5 years

Indications/Uses: Contraception with contraindication to estrogen; can suppress or reduce pain associated with dysmenorrhea or endometriosis

Benefits: Radio-opaque (can be seen on US and x-ray); does not affect breast milk supply

NEXPLANON | Source: *Navy and Marine Corps Public Health Center*

Risks: irregular bleeding patterns (78%); breakthrough bleeding; systemic effects
Contraindications: active breast cancer or liver disease or PID, known or suspected pregnancy, unexplained vaginal bleeding

Emergency Contraception
Overview

EMERGENCY CONTRACEPTION OVERVIEW

- **Indications:** Prevent pregnancy as a contraceptive method that can be used **after sexual intercourse;** Intercourse without use of contraception; Condom breakage or slippage; Missed or late doses of contraceptives; vomiting of prior dose of oral contraceptives; sexual assault
- **Efficacy:** Varies by type
- **Types:**
  - **Copper IUD** - Paragard®: most effective, requires trained provider; use up to 5 days after intercourse; long term contraceptive
  - **Emergency Contraceptive Pills** (ECPs)
    - Ulipristal Acetate (UPA)
    - Levonorgestrel
    - Combined Estrogen and Progestin (Yuzpe Regimen)

Emergency Contraceptive Pills (ECPs)

Overview

ECP OVERVIEW

Benefits: easily accessible, some are non-prescription, non-invasive
Risks: less effective with BMI >35, nausea, not effective after 3-5 days depending on method
Side effects: nausea, headache, abdominal pain, dizziness, breast pain
Types:

- **Ulipristal Acetate (UPA):** Selective progestin receptor modulator
  - Use up to 5 days after unprotected sexual intercourse
  - Must wait 5 days after taking to resume hormonal methods of birth control
  - Brands: ella®, ellaOne®, and Fibristal®
  - Requires prescription
- **Levororgestrel (LNG):** Progestin only
  - Use up to 3 days after unprotected sexual intercourse
  - Can begin using any form of birth control immediately after taking it
  - Less effective for BMIs >25
  - Brands: Plan B One-Step® and MyWay®
    - 1 Tablet of 1.5 mg of LNG or 2 Tablets of 1.5 mg of LNG
  - Does not require a prescription – over the counter at pharmacy
- **Combined Estrogen + progestin** – Yuzpe Method: higher doses of CHCs, regimen differs
  - Use up to 5 days after unprotected sexual intercourse
  - Less effective for BMIs >25 or than other methods
  - Requires prescription for CHCs

Pelvic Pain

Pelvic Pain

Obtaining Thorough History

HISTORY

- Onset, provoking/palliative, quality, radiation, associated symptoms, time
- Related to **menses**
- Related to **intercourse**
- Abnormal **vaginal discharge**
- **STI** history

Bladder pain | Source:*womenshealth.gov/*

Pelvic Pain

Definition and Differential Diagnosis

DEFINITION

- **Acute** (< 6 months) or chronic perception of pain in pelvis due to inflammatory, infectious, or traumatic injury affecting well being

DIFFERENTIAL DIAGNOSIS

- **Gynecologic:** adenomyosis, adnexal mass, PID, endometritis, leiomyoma, pelvic adhesions, vulvodynia, ectopic
- **Gastrointestinal:** diverticulitis, inflammatory bowel disease, irritable bowel syndrome
- **Urologic:** UTI, interstitial cystitis, painful bladder
- **Neuromuscular:** fibromyalgia, myofascial, muscular injury to abdominal wall), abdominal migraine
- **Psychologic:** abuse, depression, anxiety, somatic disorder, substance use
- List is not all inclusive

Abdominal Pain in Females

Overview

DEFINITION

- **Acute** (< 6 months) or chronic perception of pain in pelvis due to inflammatory, infectious, or traumatic injury affecting well being

DIFFERENTIAL DIAGNOSIS

- **Gynecologic**
- **Urologic/gastrointestinal**
- **Neuromuscular/musculoskeletal**
- **Psychological**

EVALUATION

- **Comprehensive history** and **pelvic examination**
- Labs: Urine pregnancy test (**UPT**), consider sexually transmitted infection (**STI**) testing
- Imaging: transvaginal ultrasound (**TVUS**)

TREATMENT

- Trial of NSAIDs, birth control for cycle regulation, treat causes (i.e., constipation, urinary tract infection (**UTI**)

ACUTE PAIN

- Rule out emergency
- Cervical motion tenderness – treat empirically for PID

Pelvic Masses

Evaluation and Management
Pelvic Masses

PRESENTATION:

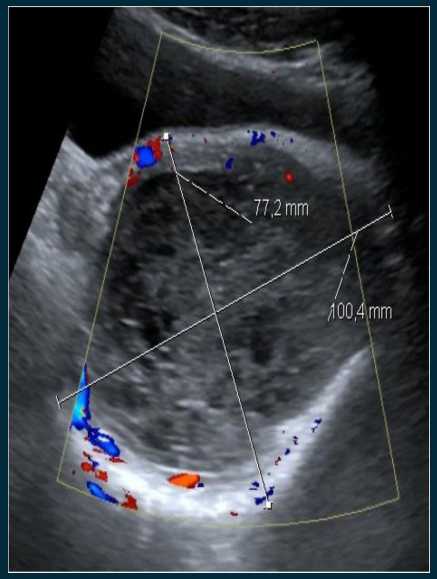
- Incidentally found on imaging
- Acute or intermittent pelvic or abdominal pain

IMAGING/LABS:

- Transvaginal ultrasound – recommended
  - Concerning ultrasound findings: cyst size > 10 cm, papillary/solid components, irregularity, ascites, high color doppler flow
- Consider tumor markers based on age (consult with OBGYN)

MANAGEMENT:

- Based on patient age and family history
- Based on size and symptoms
- **Goal – exclude malignancy**



Ovarian mass | Source:ncbi.nlm.nih.gov

REFERRAL INDICATED: TO OBGYN for any mass presumed to be of gynecologic origin

Differential Diagnosis
Gynecologic and Non-gynecologic

DIFFERENTIAL DIAGNOSIS

	Benign	Malignant
Gynecologic	• Functional ovarian cyst • Endometrioma • Tubo-ovarian abscess • Mature teratomas (dermoids) • Serous cystadenoma • Mucinous cystadenoma • Hydrosalpinx • Paratubal cysts • Leiomyomas • Müllerian anomalies	• Epithelial carcinoma • Germ cell tumor • Metastatic cancer • Sex-cord or stromal tumor
Non-gynecologic	• Diverticular abscess • Appendiceal abscess or mucocele • Nerve sheath tumors • Ureteral diverticulum • Pelvic kidney • Bladder diverticulum	• Gastrointestinal cancers • Retroperitoneal sarcomas • Metastatic cancer

Infertility Diagnosis & Evaluation

Infertility

Diagnosis, History, Possible Causes

DIAGNOSIS

- Depends on age:
  - **< age 35:** Failure to achieve pregnancy after 12 months of regular unprotected intercourse
  - **> age 35:** Failure to achieve pregnancy after 6 months of regular unprotected intercourse

HISTORY

- Determining possible etiology requires thorough menstrual and gynecologic history
- Menarche, last menstrual period, cycle regularity, pattern, duration, flow quality, intermenstrual or post-coital bleeding
- Hirsutism or acne

POSSIBLE INFERTILITY CAUSES

- Polycystic ovarian syndrome, thyroid dysfunction, endometriosis, hyperprolactinemia, uterine anomalies

REFERRAL INDICATED: Above medical conditions meeting criteria for infertility diagnosis, same sex partner, male factor infertility with proven semen analysis
Labs to order prior to referral: TSH, HgA1c, semen analysis, consider prolactin for irregular menses; additional (can consult OBGYN)

Early Pregnancy Management

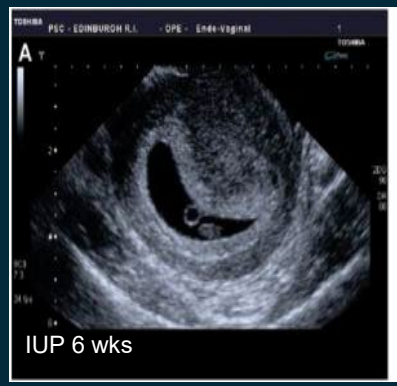
Identifying Abnormal or Emergency Pregnancy Situations

ABORTION (THREATED, INEVITABLE, INCOMPLETE, SEPTIC)

- **Threatened** — early pregnancy with vaginal bleeding and closed cervical os
- **Inevitable** — early pregnancy with vaginal bleeding and opened cervical os
- **Incomplete** — early pregnancy with vaginal bleeding and partial passage of products of conception
- **Septic** — Infected uterus in pregnancy of < 20 weeks

EPTOPIC PREGNANCY

- Pregnancy **outside of the uterus**: fallopian tube (96%), cervical, interstitial/corneal, cesarean scar, intramural, ovarian or abdominal
- **Heterotopic**: multiple gestation with one in the uterus and one extrauterine (rare)



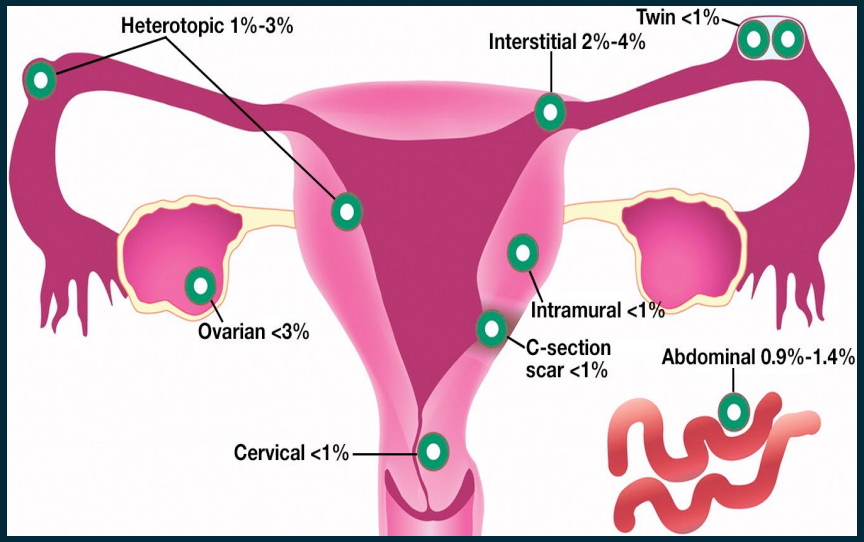
Diagnosis and Management of Ectopic Pregnancy | Source: National Institute of Health

Ectopic Pregnancy and Miscarriage

Evaluation

EVALUATE FOR THE FOLLOWING:

1. **Hemodynamic instability** → TRANSFER to higher level of care immediately
2. **Vaginal bleeding**
3. **Fever**
4. **Pelvic** or **abdominal** pain
5. **Nausea** and **vomiting** (consider ovarian torsion)
6. **Flank pain** (consider pyelonephritis or nephrolithiasis)
7. **Dysuria** (consider pyelonephritis or UTI)



Ectopic Pregnancy Sites | *rsna.org*

Ectopic Pregnancy and Miscarriage

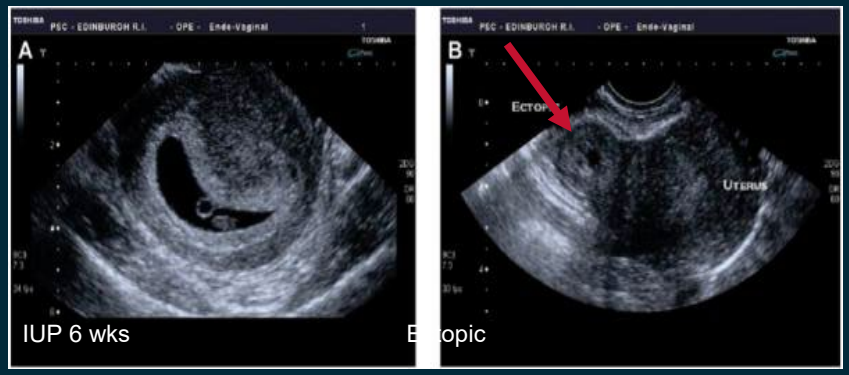
Evaluation

LABS

- Urine HCG qualitative
- Serum HCG quantitative
- Urine Analysis (UA)
- Complete blood count (CBC)
- Gonorrhea and Chlamydia
- ABO/Rh Blood Type

IMAGING

- Transvaginal Ultrasound with complete evaluation of uterus and adnexa



Diagnosis and Management of Ectopic Pregnancy | Source: National Institute of Health

Focused Assessment with Sonography in Trauma (FAST) Exam

- Evaluates for free fluid in abdomen
- Perform if concern for hemodynamic instability

Transvaginal ultrasound (if available and provider qualified)

- Diagnosis of intrauterine pregnancy (IUP) requires gestational sac (GS) with yolk sac (YS) and/or embryo in adnexa.

Ectopic Pregnancy and Miscarriage

Diagnosis

ECTOPIC

- **Until proven otherwise** (i.e., if no GS and YS seen in uterus)
- Concern based on **pain, vaginal bleeding**
- Inappropriate rise or **fall of Human Chorionic Gonadotropin (HCG) values** without clear intrauterine pregnancy seen

MISCARRIAGE (generic catch all term for spontaneous/incomplete/missed abortion)

- Loss of prior **fetal cardiac activity**
- **Inappropriate developmental timeline** of fetal structures on US
- Inappropriate change in **HCG values**

Ectopic Pregnancy and Miscarriage

Diagnosis

Table 2. Guidelines for Transvaginal Ultrasonographic Diagnosis of Pregnancy Failure in a Woman with an Intrauterine Pregnancy of Uncertain Viability.*

Findings Diagnostic of Pregnancy Failure	Findings Suspicious for, but Not Diagnostic of, Pregnancy Failure†
Crown–rump length of ≥7 mm and no heartbeat	Crown–rump length of <7 mm and no heartbeat
Mean sac diameter of ≥25 mm and no embryo	Mean sac diameter of 16–24 mm and no embryo
Absence of embryo with heartbeat ≥2 wk after a scan that showed a gestational sac without a yolk sac	Absence of embryo with heartbeat 7–13 days after a scan that showed a gestational sac without a yolk sac
Absence of embryo with heartbeat ≥11 days after a scan that showed a gestational sac with a yolk sac	Absence of embryo with heartbeat 7–10 days after a scan that showed a gestational sac with a yolk sac
	Absence of embryo ≥6 wk after last menstrual period
	Empty amnion (amnion seen adjacent to yolk sac, with no visible embryo)
	Enlarged yolk sac (>7 mm)
	Small gestational sac in relation to the size of the embryo (<5 mm difference between mean sac diameter and crown–rump length)

* Criteria are from the Society of Radiologists in Ultrasound Multispecialty Consensus Conference on Early First Trimester Diagnosis of Miscarriage and Exclusion of a Viable Intrauterine Pregnancy, October 2012.

† When there are findings suspicious for pregnancy failure, follow-up ultrasonography at 7 to 10 days to assess the pregnancy for viability is generally appropriate.

Ectopic Pregnancy and Miscarriage

Treatment

ECTOPIC

- Emergent transfer of care to facility with surgical capabilities (GYN) for possible surgical management
- Management types
  - Expectant: not performed routinely in the US
  - Methotrexate: IM injection, requires monitoring and ability to perform surgery
  - Surgical: Salpingectomy vs. salpingostomy (requires skilled surgeon)

MISCARRIAGE Loss of prior **fetal cardiac activity**

- Management depends on patient preference, provider skills, and local resources
- Management types
- Expectant: watch and wait – can take up to 8 weeks for tissue to pass
- Medical management: improved success, 24 - 48 hrs, counseled on heavy bleeding
- Surgical management: immediate intervention

CONSULT OBGYN UNLESS PROVIDER SKILLED IN TREATMENT

Early Pregnancy

Nausea and Vomiting

TREATMENT

- Early treatment **may prevent progression** to severe condition
- **Nonpharmacologic** (first line)
  - Dietary changes: small frequent meals every 1-2 hours, avoidance of spicy or fatty foods, consumption of high protein snacks
  - Convert prenatal vitamins (PNV) to folic acid supplements only
  - Trial Ginger capsules
- **Pharmacologic**
  - Vitamin B6 (pyridoxine) with Doxylamine (Unisom), previously Diclegis

REFERRAL INDICATED

- **Uncontrolled symptoms** despite first line interventions
- Evidence of **dehydration** (hypotension, tachycardia) and / or **starvation** (ketonuria)
- Already established **OB Care** in place

Medical Evacuation (MEDEVAC) for Women's Health-Related Concerns

Indications for MEDEVAC

Overview

PATIENTS WHO REQUIRE ESCILATION OF CARE

REQUIRES INPATIENT ADMISSION:

- Pyelonephritis
- Uncontrolled nausea / vomiting
- Difficulty maintaining airway
- Infection requiring antibiotics
- Septic abortion
- Tubo-ovarian abscess

WHERE TO GO:

- Nearby MTF
- Nearby civilian facility
- Host-nation facility
- Nearest military medical resource

HOW TO GET THERE:

- Privately Owned Vehicle (POV)
- Ambulance
- Air

REQUIRES SURGICAL INTERVENTION

- Appendicitis
- Ovarian torsion

HEMODYNAMIC INSTABILITY

- Shock
- Uncontrolled bleeding
  - Vaginal bleeding
  - Internal bleeding

MEDEVAC | defense.gov

References

1. CDC – Bacterial Vaginosis (Link)
2. CDC – Contraception App (Link)
3. CDC – Contraceptive Efficacy (Link)
4. CDC – Heavy Menstrual Bleeding (Link)
5. CDC – Trichomonas (Link)
6. CDC – Vaginal Discharge (Link)
7. US Department of Health and Human Services – Bladder Pain (Link)
8. US Department of Health and Human Services – Menstrual Cycle (Link)
9. Medline Plus – Yeast Infections (Link)
10. National Center for Biotechnology Information – Vulvar Contact Dermatitis (Link)
11. New Health Advisor – Menstrual Cycle Phases (Link)
12. NIH – Early Pregnancy Loss (Link)
13. NIH – Ectopic Pregnancy (Link)
14. NIH – Ovarian Mass (Link)
15. NMCPHC Women's Health Webpage – Copper IUD (Link)
16. NMCPHC Women's Health Webpage – Decide and Be Ready App (Link)
17. NMCPHC Women's Health Webpage – NEXPLANON (Link)
18. NMCPHC Women's Health Webpage – IUDs (Link)
19. RSNA – Ectopic Pregnancy Sites (Link)

Questions & Answer Session

Women's Health Seminar

SESSION 3: WOMEN'S HEALTH CONSIDERATIONS PRIOR TO AND DURING DEPLOYMENT

CDR Carolyn Ellison; APRN-C

Director of Public Health Services, Public Health Emergency Officer, Family Nurse Practitioner, Sexual Assault Medical Forensic Examiner

Navy Medicine Readiness and Training Command Bremerton, WA

Presenter: CDR Carolyn Ellison

- CDR Carolyn Ellison, APRN-C
- Director of Public Health Services, Public Health Emergency Officer, Family Nurse Practitioner, Sexual Assault Medical Forensic Examiner
- Navy Medicine Readiness and Training Command
- Bremerton, WA

Disclosures

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Learning Objectives

LEARNING OBJECTIVES

- Understand methods of menstrual management
- Review of prevention preparation for common women's health infections
- Discuss sexual assault, pre – deployment conversations, and supplies and medication
- Highlight post-deployment considerations

Background

Background

Deployment Challenges and Priorities

Deployed environments create **unique challenges** for women and their ability to **ensure appropriate health maintenance**.

CHALLENGES

- Women can feel ill-prepared for **maintaining health** while deployed.
- **Packing and storage space** for necessary hygiene supplies may be limited.
- Resupply of hygiene supplies may be limited.
- Austere or remote locations may not be well equipped to support acute women health needs.

MEDICAL LEADERS SHOULD PRIORITIZE

- Understanding the **limitations** of the deployed environment.
- Ensure women receive **education and preparation resources**.
- Prepare for anticipated supplies, equipment, medications needed to support female population.

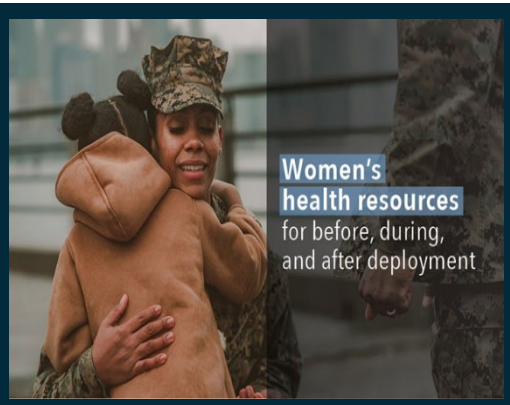

Photo | Source : health.mil

Photo | Source : navy.mil

Menstrual Management Education

Menstrual Management Education

Supply Education Points and Contraceptive Options

CONTRACEPTIVE OPTIONS

- Options include OCPs, NuvaRing, intrauterine devices, implants, or Depo Provera.
- Encourage women to **start discussion** of options with primary care provider at least 6 months before deployment.
  - May take several appointments to determine best option.
  - Best to have steady state of menstruation or suppression prior to deployment.
- Advise women that deployment may change normal menstrual patterns and options may need to change during deployment.
- Ensure **different contraceptive options** are ordered and available during deployment.

SUPPLY EDUCATION POINTS

- Best option for bleeding management based on preference (i.e., pads, tampons, menstrual cups/discs, and/or period underwear)
- Length of deployment
- Can all supplies be carried? Will resupply be needed? Is resupply reliable? Are there local options for resupply?

Ensure menstrual supplies are ordered along with AMAL requirements in case of op tempo changes or unexpected needs by personnel.

Prevention Preparation for Common Women's Health Infections

Prevention Preparation

Common Women's Health Infections

URINARY TRACT INFECTIONS

- **Recurrent episodes** may benefit from **prophylactic** treatment.
  - Consider having women **carrying an antibiotic** course to start as soon as symptoms occur.
- Encourage operational leaders to allow for regular opportunities for **voiding** & to promote **adequate hydration** throughout the day.
- Ensure medical has **appropriate antibiotics** available for treatment.

YEAST & BACTERIAL INFECTIONS

- **Recurrent episodes** may benefit from **prophylactic** treatment.
  - Consider having women **carry medication** to start as soon as symptoms occur.
- Encouraged **well-fitting underwear,** cotton over nylon.
- Encourage women to carry **baby wipes** or have extra water for hygiene purposes if showers not readily available.

VULVITIS

- **Vulvar irritation** can occur from heat, vaginal infections, or friction from uniforms.
- Encourage **well-fitting underwear**, regular changing.
- Ensure **appropriate medications** available for treatment.

Supplies and Medications

Supplies and Medications

Ensure Availability

Although operational tempo and environment may dictate some availability of supplies, it's important to **ensure maximum availability** of supplies for individualized care when possible.

MEDICATIONS

- OCPs, Nuvaring, depo provera
- Non-steroidal anti-inflammatory medications
- Oral antifungal like Diflucan
- Antibiotics for UTI and bacterial vaginosis
- Topical antifungal (miconzaole) and barrier cream (zinc oxide) to treat vulvitis
- Iron supplementation for heavy bleeding

SUPPLIES

- Tampons, pads in various sizes
- Hand sanitizers, body wipes, toilet paper, zip lock bags
- Female urination devices (FUD)
- Perineal irrigation bottles

Response to Sexual Assault

Response to Sexual Assault
Overview

SEXUAL ASSAULT RESPONSE

- Ensure all personnel **understand reporting options** and availability of services during deployment.
- Ensure a Standard Operating Procedures (SOPs) is in place to address various situations.
- Understand **timeliness of MEDEVAC services** and options for evidence collection if delayed.
- Ensure availability for **Sexual Assault Forensic Exam (SAFE)** with either available SAMFE on deployment or nearest MTF.
  - **Mental Health**: Diagnosis of Gender Dysphoria must be documented or validated by a military mental health provider

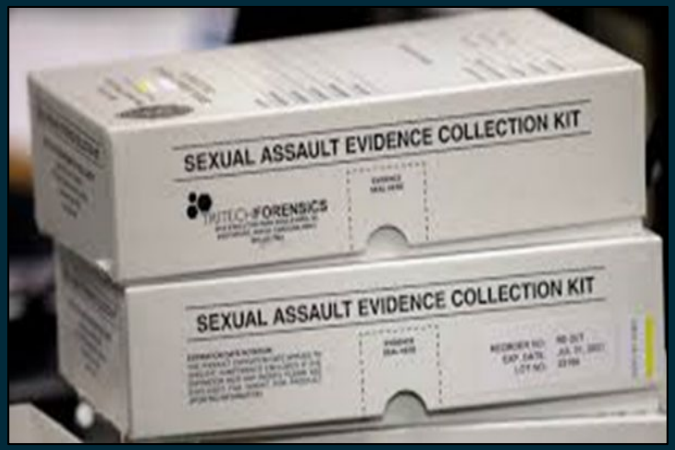

Photo | Source : *tricare.mil*

Pre-Deployment Discussions

Pre-Deployment Preparation

Pre-deployment discussions

Medical teams should provide an in-depth **pre-deployment discussion** about women's health concerns and availability of supplies. This garners trust as well as increases women's comfort to speak up during deployment when issues first arise.

Photo | Source : navy.mil

Photo | Source : navy.mil

Hygiene Practices

Deployment Considerations

Hygiene Practices

Hygiene Preparation & Practices

- Ensure availability of hand washing stations and/or adequate supply of hand sanitizer.
- Ensure opportunities for women to empty their bladder.
- Ensure ready availability of hydration fluids.
- Ensure ready availability of showers if possible or enclosed wash stations.
- Check-in regularly and specifically ask about any women's health-related concerns.
- Addressing concerns early may later reduce impact to operational mission.

Photo | Source: defense.gov

Follow-up for Women's Health Concerns

Post-Deployment Considerations

Follow-up for Women's Health Concerns

- **Empower women to seek follow-up care for new or worsening conditions after deployment.**
  - Facilitate referrals to local MTF resources.
- **Ensure deployment related conditions are appropriately documented**.
  - Medical injuries or potential chemical, environmental exposures.
- **Perform an After Action Report (AAR)**
  - Discuss medical situations that could not be adequately evaluated or addressed.
  - Lack of necessary supplies, medications, or equipment to provide standard care.
  - Make recommendation for improved preparation for next deployment in that area of operation (AOR).

Photo | Source: defense.gov

Reproductive Health Concerns

Post-Deployment Considerations

Reproductive Health Concerns

Deployment may interrupt reproductive plans. Empower women to **address these issues as soon as they return from deployment**.

Specialty care can require weeks to receive an appointment so medical leadership should ensure referrals are placed early in re-deployment to maximize a **medically ready force** for the next mission.

Photo | Source: defense.gov

References

1. Defense.gov – Photo (Link)
2. Health.mil – Photo (Link)
3. Health.mil – Women's Health Deployment Resources (Link)
4. Navy.mil – Photo (Link)
5. TriCare – Sexual Assault Evidence Collection Kit (Link)

Questions & Answer Session

Conclusion : Day 1

THIS CONCLUDES DAY 1 OF THE VIRTUAL WOMEN'S HEALTH SEMINAR

- **REMINDER: You must register by 1300 ET on January 28th** to qualify for the receipt of CE/CME credit or certificate of attendance. *Please locate instructions for obtaining CE/CME credit in your email from 24 January.*
- **Day 2 will begin tomorrow at 1000 ET** with a presentation on *Ongoing Efforts by the Office of Women's Health and the Female Force Readiness Navy Medicine Operational Clinical Community* by LCDR Allison Eubanks.
- Please plan to log on by **09:45 ET** and ensure **your name is displayed** on Teams.
- Thank you for your participation!

Women's Health Seminar

DAY 2: SESSIONS 4 – 6

26 January 2023, 1000 ET – 1400 ET

Seminar Overview

26 January 2023: Day 1

- 1000 ET: Opening Remarks; CDR Heather Hauck
- 1010 ET: Preventative Healthcare for Service Women; LCDR Jody Joynt
- 1130 ET: Understanding Common Women's Health Concerns; LT Adrienne Gillis
- 1300 ET: Women's Health Considerations Prior to and During Deployment; CDR Carolyn Ellison
- 1400 ET: End of Day Remarks; CDR Heather Hauck

27 January 2023: Day 2

- 1000 ET: Opening Remarks; LCDR Ayeetin Azah
- 1010 ET: Ongoing Efforts Led by the OWH and FFR NMOCC; LCDR Allison Eubanks
- 1100 ET: Mental Healthcare and Substance Abuse; CDR Heather Shibley
- 1230 ET: Transgender Healthcare; CDR Janelle Marra and LCDR Amanda Bucknum
- 1400 ET: Closing Remarks; LCDR Ayeetin Azah

Women's Health Seminar

Session 4: Ongoing Efforts Led by the Office of Women's Health (OWH) and Female Force Readiness Navy Medicine Operational Clinical Community (FFR NMOCC)

LCDR Allison Eubanks, M.D.

Staff Physician, Obstetrics and Gynecology

Navy Medicine Readiness and Training Center; Rota, Spain

Presenter: LCDR Allison Eubanks

- LCDR Allison Eubanks, M.D.
- Staff Physician, Obstetrics and Gynecology
- Navy Medicine Readiness and Training Center
- Rota, Spain

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Learning Objectives

LEARNING OBJECTIVES

- Provide an overview of the various FFR NMOCC Sub-Community Boards (SCBs) and their initiatives
- Discuss useful resources created by the FFR NMOCC
- Highlight the Women's Health Webpage and its many useful resources

OWH Priorities

The mission of Navy Medicine's OWH is to keep as many active duty female Sailors and Marines in full duty status as possible by supporting their medical readiness and ensuring that women's health is an integral component of total fleet health.

Health Literacy

Improve health literacy and empower self-care among service women.

Medically Ready Force

Equip a medically ready force to provide quality women's healthcare.

Cultivate Culture

Cultivate a culture that encourages proactive management of female readiness to support service women throughout their careers.

Shape Policy

Shape Navy and Marine Corps policy to advance women's healthcare and solidify comprehensive women's health standards.

Ongoing Process Improvement Efforts

Embedded Women's Health Provider (EWHP) Program

To extend the services and benefits of EWHPs in advancing readiness, the OWH is coordinating with Navy Personnel Command to establish the appropriate billets.

PURPOSE & IMPACT

- The EWHP Pilot (OCT 2020 - MAY 2021) shifted women's health providers to a more readily accessible location for the active duty population (e.g., the waterfront).
- Services included contraception, well-woman care, menstrual management, screening for sexually transmitted infections (STIs), pap tests, and point-of-care pregnancy tests.
- Due to the success of the EWHP Pilot, the OWH is facilitating **EWHP Program expansion** to further increase force readiness and support operational providers.
- The OWH received support from Navy Medicine to establish two billets in the General Medical Officer (GMO) to Operational Medical Officer (OMO) transition as Family Medicine Physicians to serve were EWHPs at Medical Readiness Division (MRD) for the Summer 2023 Permanent Change of Station (PCS) season.

EWHP PILOT READINESS IMPACT

987 estimated duty hours have been saved due to EWHP access.

67 operational providers received formal women's healthcare training from the EWHP.

Access to Contraceptive Services

Walk-In Contraceptive Clinics (WICCs) offer easy access to same-day contraceptive services for service women.

PURPOSE & IMPACT

- Currently, 24 WICCs are open (14 Naval, 4 Air Force, 3 Army, 2 National Capital Region, and 1 Joint-base locations), improving patient satisfaction, and targeting service women at risk for unintended pregnancy.
- In response to the COVID-19 Pandemic, many PINC clinics shifted to either a telehealth platform, or asking service members to call ahead of arrival to encourage social distancing.
- On 27 September 2022, a Defense Health Agency- Administrative Instruction (DHA-AI) mandated to standardize and make walk-in contraception services available for active duty service members and eligible beneficiaries at all Military Medical Treatment Facilities (MTFs).
    - Each location has the discretion to provide walk-in contraception services at times and durations of their choosing to meet the reproductive healthcare needs of service members. However, the service must be offered on a minimum of a weekly basis.

READINESS IMPACT	In 2020, an estimated **46%** of female sailors' pregnancies were unplanned.[1] **3,440,387** non-deployable days result from unintended pregnancy annually.[2,3]	Improved long-acting reversible contraception (LARC) rates among service women result in **increased operational readiness** of service members.

Women's Health Proficiencies for Operational Providers

The BUMED OWH, Fleet leadership, and operational providers endorse five women's health proficiencies as four requirements and one recommendation to be reflected in operational providers' privileges and core competencies.

PURPOSE & IMPACT

- Currently**, comprehensive women's healthcare is inconsistently available** and delivered to active duty women, which creates risk to female force readiness and Naval superiority.
- Active duty service women comprise 21% of the Navy and 9% of the Marine Corps. There is **a need for a paralleled evolution in the way their healthcare is delivered and accessed**.
- **20% of GMOs and 22% of IDCs** reported they were **not adequately trained** or resourced to treat commons women's health issues.
- Led by BUMED OWH and the Female Force Readiness Navy Medicine Operational Clinical Community, **the Operational Provider Training Development Working Group** was established to **create the curriculum and training materials** to equip operational providers in the five women's health proficiencies.

RECOMMENDED PROFICIENCIES

1. Must be able to provide basic preventive healthcare services to female service members and counsel female service members on proper self-care, preventive practices, and personal hygiene.
2. Must be able to effectively recognize gynecologic conditions that require escalation to specialist care.
3. Must be able to diagnose pregnancy, identify emergency pregnancy situations, and follow proper safety procedures in emergency pregnancy situations.
4. Must be able to provide comprehensive contraceptive counseling on the full range of contraceptive methods.
5. Recommend NEXPLANON® credentialing / proficiency for placement and removal. *(Not a requirement).*

Responding to *Roe v. Wade*

The OWH is continuing to monitor and analyze the impact of the overturning of *Roe v. Wade* for patients and providers across the country.

CURRENT CHALLENGE AND NEXT STEPS

- On 24 June 2022, *Roe v. Wade* was overturned by the Supreme Court; access to abortion care will be determined by state law.
- Currently, TRICARE-covered abortions (for a pregnancy that is the result of rape, incest, or would endanger the life of the pregnant person) can be **performed at medical treatment facilities** (MTFs) and **civilian health facilities by TRICARE-authorized providers**.
- Abortions not covered by TRICARE will require the service member to comply with state laws and pay out of pocket (travel may be required).
- The OWH is collaborating with Navy leadership, all Services, and DHA to mitigate impending barriers to access and ensure service members and beneficiaries can exercise their right to reproductive care.
- Unplanned pregnancies will continue to be a threat to force readiness. The OWH will continue to ensure access to contraceptive care to reduce this risk.

LEADERSHIP RESPONSE

After the Supreme Court decision in *Dobbs v. Jackson Women's Health Organization,* **U.S. Under Secretary of Defense** Gilbert R. Cisneros, Jr. stated "as Secretary Austin has made clear, nothing is more important than the health and well-being of our service members, the civilian workforce, and DoD families, and we are committed to taking care of all of our people and ensuring that the entire Force remains ready and resilient."

FFR NMOCC Overview

FFR NMOCC Structure

The FFR NMOCC is a multidisciplinary body of Navy and Marine Corps leaders and providers that collaborate with the OWH to optimize medical readiness, resiliency, and lethality of the female force.

Female Force Readiness Advisory Board
(FFRAB), Voting Body

The FFRAB is the voting body of the FFR NMOCC and **oversees the three sub-communities and two working groups** (WGs) listed below. Membership consists of individuals from various specialties, including mental health, women's health, and primary care, along with operational providers, and researchers.

- **Family Planning Sub-Community Board (FPSCB)**
- **Mental Health Sub-Community Board (MHSCB)**
- **Neuromusculoskeletal Sub-Community Board (NMSK SCB)**
- **Operational Provider Training Development WG**
- **Women's Health Seminar WG**

Family Planning Sub-Community Board (FPSCB)

The FPSCB consists of more than 25 members from various specialties including obstetrics and gynecology (OB/GYN), family medicine, certified nurse midwives (CNMs), and pharmacy.

MISSION

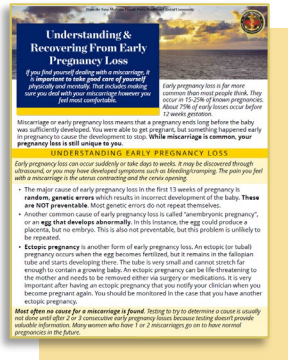
Provide comprehensive family planning care by promoting Navy-wide collaboration and PI to enhance health outcomes and optimize mission readiness for active duty female Sailors and Marines.

PREVIOUS ACCOMPLISHMENTS

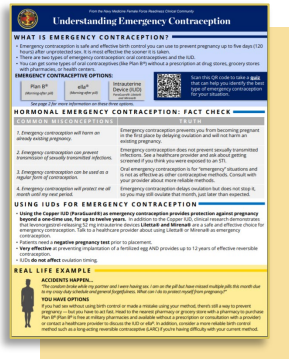
- Created and refreshed 11 Provider Treatment Algorithms to assist operational providers in recognizing and treating women's health concerns within their scope of practice.
- Supported development of **Walk-In Contraceptive Clinics** to offer easy access to walk-in, same-day contraceptive services, targeting service members at risk for unintended pregnancy. There are currently 14 open Naval Walk-In Contraceptive Clinics.
- The FPSCB produced **resources to advance family planning care**, including:
  - Service Member Guide: Recovery from Early Pregnancy Loss
  - Service Member Handout on Emergency Contraception

FUTURE GOALS

- The FPSCB is developing resources to empower service members and providers to optimize women's healthcare and promote readiness, including a new **nurse-run protocol to guide treatment of service members with vaginal discharge** and patient guides on proper self-swabbing protocol.



Service Member Guide: Recovery From Early Pregnancy Loss



Service Member Handout on Emergency Contraception

Family Planning Sub-Community

Recent Projects

EDUCATIONAL RESOURCES

- Contraception:
  - *Decide, Be Ready* – Phone app to assist service members decide which contraceptive method is best
  - *Menstrual Suppression* – pamphlet
  - *Recruit Contraception Fast Facts* – document for recruits on the most up to date information
  - *Service Member Handout on Emergency Contraception* – consolidated fast facts regarding options and how to obtain them
- *Service Member Guide: Recovery from Early Pregnancy Loss*
- *11 Provider Treatment Algorithms* – Assist operational providers in recognizing and treating women's health concerns

Mental Health Sub-Community (MHSCB)

The MHSCB consists of more than 35 members from various specialties including psychiatry, social work, psychology, and behavioral health.

MISSION

Ensure the delivery of comprehensive, evidence-based mental healthcare-in support of active duty readiness and retention, as well as family member care, by promoting Enterprise-wide collaboration, formalization, and process improvement (PI) through education and research.

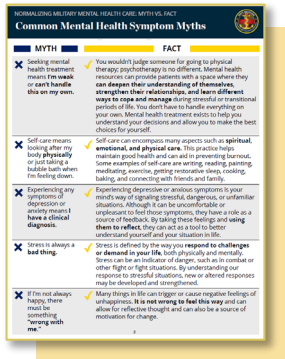
PREVIOUS ACCOMPLISHMENTS

- Supported development and execution of a **Mental Health Provider Survey** to assess Navy Medicine mental health providers' capabilities to treat female-specific mental health concerns. Survey was designed to identify gaps in current provider capabilities and inform future trainings.
- The **MHSCB developed guides / resources** for service members on various topics, including: Intimate Partner Violence and Normalizing Mental Healthcare

Reporting Intimate Partner Violence

FUTURE GOALS

- Future potential initiatives include :
  - Developing a resource on **comprehensive well-being** focused on the critical nature of self-care and wellbeing to maintain warfighter strength, toughness, and resiliency.
  - Developing a resource to support the **reintegration of service members after deployment**.



Normalizing Military Mental Healthcare: Myth vs. Fact

Mental Health Sub-Community

Current Resources

EDUCATIONAL RESOURCES

Cultural Competency Training Guide

- Assist operational providers' abilities to expand their leadership's understanding of Women's Readiness issues

Resource on Navigating Infertility as a Service Woman

- Inform service members about options for treatment of infertility and options for support during these processes

Normalizing Military Mental Health Care: Myth vs. Fact

- Addresses concerns regarding career impact when seeking MH, medical vs. non-medical MH resources, and other common concerns

Intimate Partner Violence Patient Reporting Flowchart

- Clearly outlines the possible reporting options for patients

Neuromusculoskeletal Sub-Community Board (NMSK SCB)

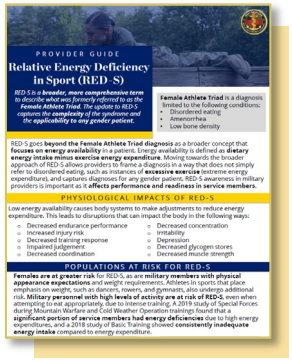
The NMSK SCB consists of more than 20 members from various specialties, including family medicine, nutrition, sports medicine, physical therapy, and occupational medicine.

MISSION

Provide comprehensive, evidence-based neuromusculoskeletal care by promoting Navy-wide collaboration and PI between Fleet, Marine, and medical assets to improve health outcomes, operational mission readiness, and retention rates for all active duty female Sailors and Marines.

PREVIOUS ACCOMPLISHMENTS

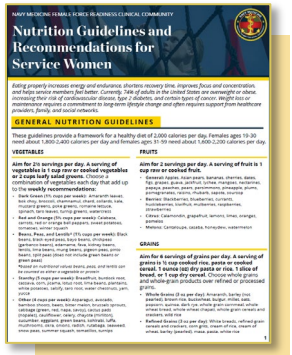
- Routed a point paper on Pelvic Floor Physical Therapy (PFPT) to the Medical Officer of the Marine Corps recommending different courses of action (COAs) to support PFPT for service members, based on demonstrated demand for this service.
- The **NMSK SCB developed guides / resources** for service members on various topics, including: Relative Energy Deficiency in Sport (RED-S) and Nutrition Guidelines and Recommendations for Service Women



Provider Guidance on RED-S

FUTURE GOALS

- The group is developing a **self-directed video exercise program** to prevent back and hip injuries among service members.
- The NMSK SCB is currently developing two point papers:
  - Recommendations to **support pre-enlistment injury prevention training**, including additions to the Navy Operational Fitness and Fueling System (NOFFS) App for Navy Recruits.
  - Recommendations to address gender disparities in the Navy Body Composition Program.



Nutrition Guidelines and Recommendations for Service Women

FFR NMOCC Accomplishments and Resources

Navy Medicine Women's Health Website

The OWH partnered with the Navy and Marine Corps Public Health Center (NMCPHC) to develop a Women's Health Website to house women's health resources for female Sailors and Marines, their operational leadership, and their providers to advance force readiness.

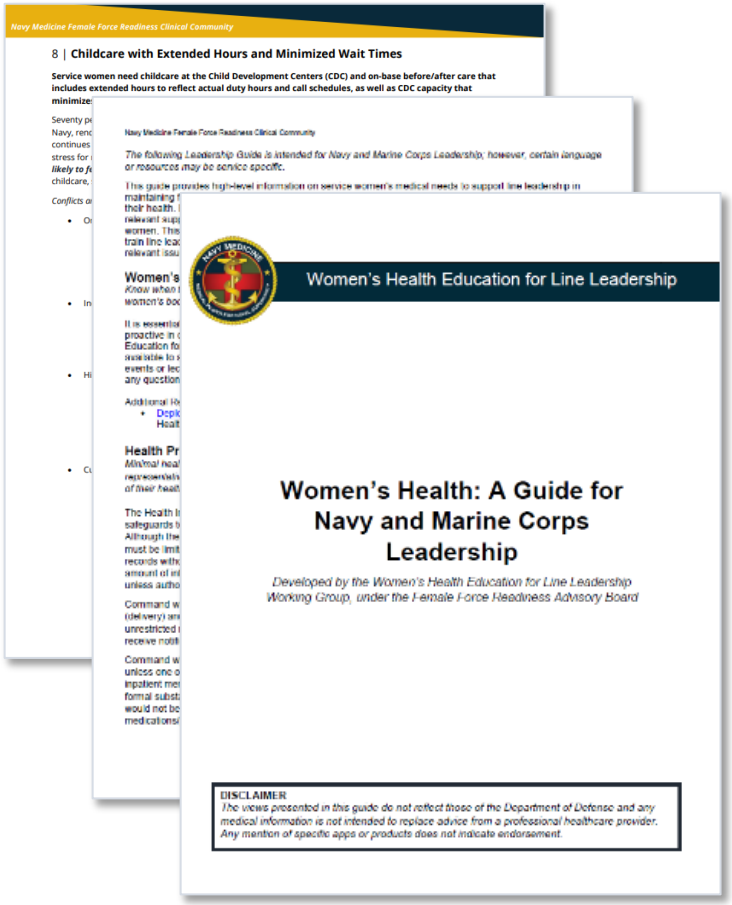
Topics include contraception, menstrual management, nutrition, neuromusculoskeletal, mental health, general women's health, policies and instructions, resources for leadership, provider resources, and advertising resources.

NAVY MEDICINE WOMEN'S HEALTH WEBSITE

- Provides service members, leadership, and providers with women's health information categorized by women's health topic.
- After selecting the Women's Health Topic of choice, a list of hyperlinked resources will populate for easy access.
- Website contains 90+ resources and relevant policies and receives ~600 page views per month.
- Access the website via this link or the QR Code to the right. The website is optimized for mobile devices.

For Leaders: Women's Health Education Guide

A guide which summarizes key factors of women's readiness and leadership's role in fostering a supportive environment for women to proactively manage their health and readiness.

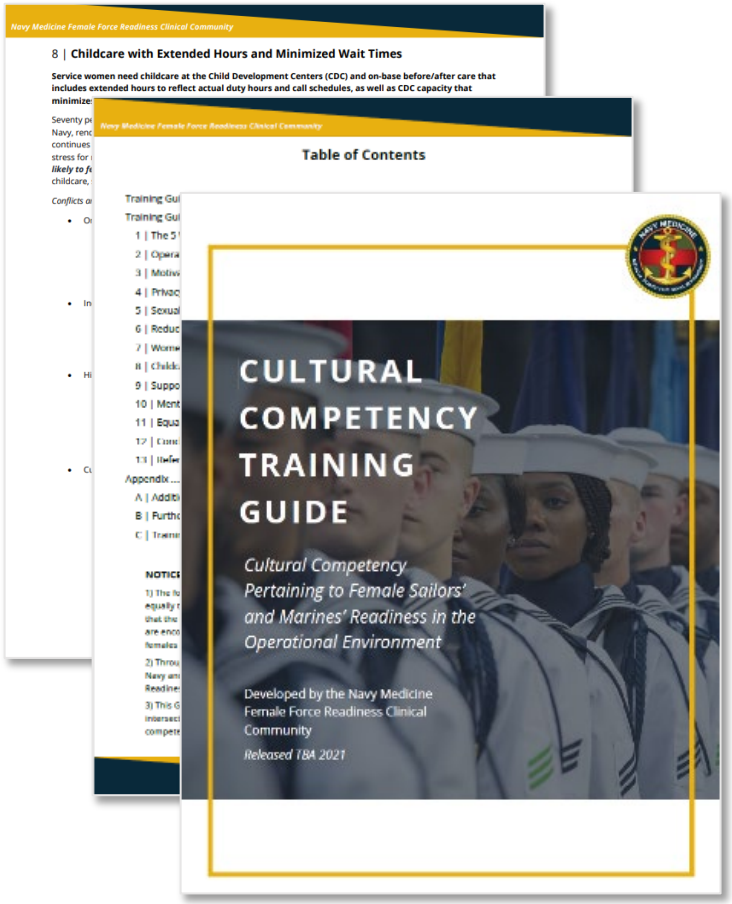


LEADERSHIP GUIDE

- Provides high-level information on service **women's medical readiness needs** to support line leadership in maintaining force readiness and fostering a supportive environment for women to proactively manage their health.
- The guide provides line leaders with an overview of **relevant women's health knowledge**, health privacy and confidentiality, and why understanding women's health is essential for increasing force readiness.
- Each section includes **additional supporting resources** (e.g., Navy and Marine Corps policies, relevant support services, and education resources) that leadership can make available to service members.
- This Guide is available here on the **Women's Health Webpage.**

For Leaders: Cultural Competency Guide

Resource for Navy and Marine Corps leadership to understand cultural competency and its importance for the readiness of service members.

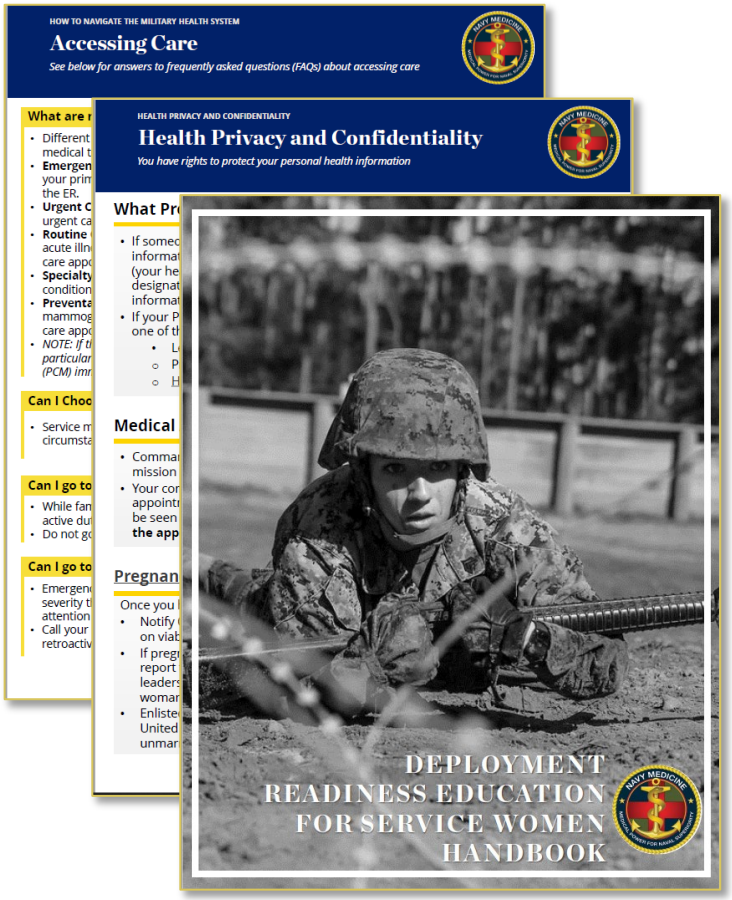


CULTURAL COMPETENCY

- This guide offers a self-paced learning resource introducing cultural competency and its importance to service members' readiness for Navy and Marine Corps leadership to identify knowledge gaps and promote further learning.
- The resource covers eight high priority needs for female Sailors and Marines, and details suggested actions that leaders can take to address each need.
- This Guide is available here on the Women's Health Webpage.

For Service Members: DRES Handbook

The Deployment Readiness Education for Service Women (DRES) Handbook includes information on healthy practices and available resources to support service women's healthcare needs and challenges before and during deployment.



DRES HANDBOOK

- The OWH and FFR NMOCC developed the DRES Handbook, a user-friendly digital resource that covers important healthcare information for service women to reference pre-, during, and post-deployment.
- The DRES Handbook was developed into a tri-service Mobile App by the DHA.

Scan the quick response (QR) code here to download the **DRES Mobile App.**

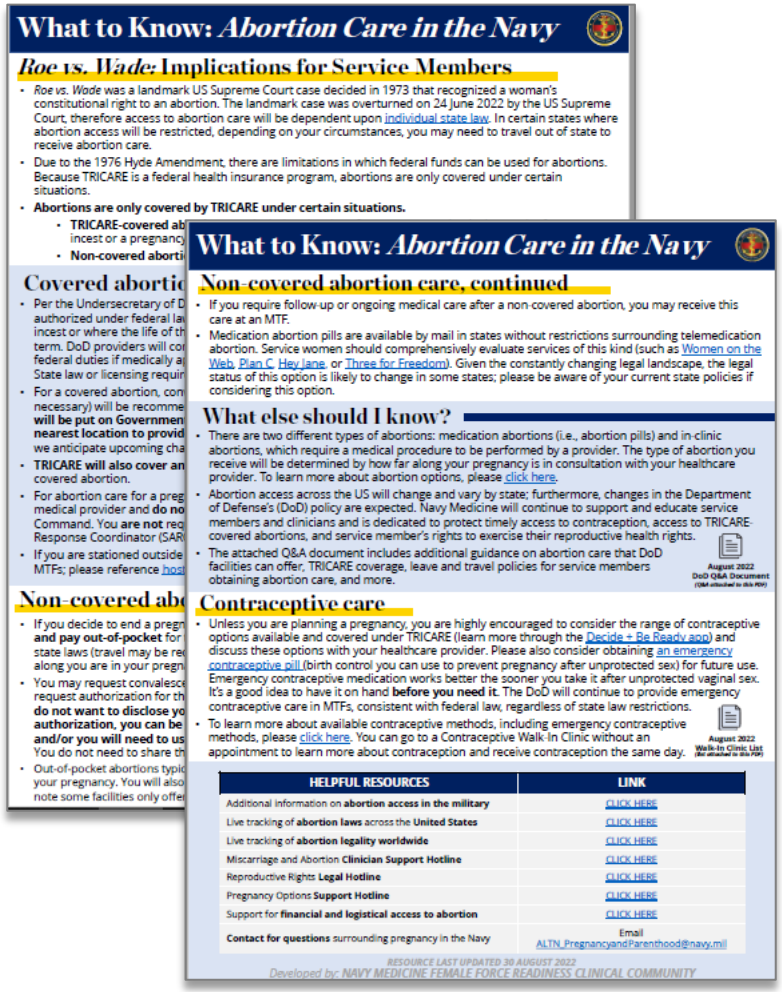
- The OWH is conducting an IRB-approved study (Winter – Spring 2023) to assess whether use of the DRES App affects health-related behaviors amongst female Marines.

For Service Members: Abortion Care Handout

This resource provides background on abortion care in the military and current abortion care options through military and civilian care.

ABORTION CARE EDUCATION

- The What to Know: *Abortion Care in the Navy* Handout includes information on abortion care in the Navy to inform service members on their current options. This handout:
  - Describes the different types of contraceptive care and what is covered under TRICARE.
  - Highlights the difference between a TRICARE covered abortion vs. a non-covered abortion.
  - Provides resources on abortion laws across the United States and worldwide to keep service members informed on the changing policy landscape.
  - The handout is available here on the Women's Health Webpage.



What to Know: *Abortion Care in the Navy*

Roe vs. Wade: Implications for Service Members

- *Roe vs. Wade* was a landmark US Supreme Court case decided in 1973 that recognized a woman's constitutional right to an abortion. The landmark case was overturned on 24 June 2022 by the US Supreme Court, therefore access to abortion care will be dependent upon individual state law. In certain states where abortion access will be restricted, depending on your circumstances, you may need to travel out of state to receive abortion care.
- Due to the 1976 Hyde Amendment, there are limitations in which federal funds can be used for abortions. Because TRICARE is a federal health insurance program, abortions are only covered under certain situations.
- **Abortions are only covered by TRICARE under certain situations.**
  - **TRICARE-covered ab** incest or a pregnancy
  - **Non-covered aborti**

Covered aborti

- Per the Undersecretary of D authorized under federal la incest or where the life of th term. DoD providers will co federal duties if medically a State law or licensing requir
- For a covered abortion, con necessary) will be recomme **will be put on Governmen nearest location to provid** we anticipate upcoming cha
- **TRICARE will also cover an** covered abortion.
- For abortion care for a preg medical provider and **do no** Command. You **are not** req Response Coordinator (SAR
- If you are stationed outside MTFs; please reference host

Non-covered abo

- If you decide to end a pregn **and pay out-of-pocket** for state laws (travel may be re along you are in your pregn
- You may request convalesc request authorization for th **do not want to disclose yo authorization, you can be and/or you will need to us** You do not need to share th
- Out-of-pocket abortions typic your pregnancy. You will also note some facilities only offe

What to Know: *Abortion Care in the Navy*

Non-covered abortion care, continued

- If you require follow-up or ongoing medical care after a non-covered abortion, you may receive this care at an MTF.
- Medication abortion pills are available by mail in states without restrictions surrounding telemedication abortion. Service women should comprehensively evaluate services of this kind (such as Women on the Web, Plan C, Hey Jane, or Three for Freedom). Given the constantly changing legal landscape, the legal status of this option is likely to change in some states; please be aware of your current state policies if considering this option.

What else should I know?

- There are two different types of abortions: medication abortions (i.e., abortion pills) and in-clinic abortions, which require a medical procedure to be performed by a provider. The type of abortion you receive will be determined by how far along your pregnancy is in consultation with your healthcare provider. To learn more about abortion options, please click here.
- Abortion access across the US will change and vary by state; furthermore, changes in the Department of Defense's (DoD) policy are expected. Navy Medicine will continue to support and educate service members and clinicians and is dedicated to protect timely access to contraception, access to TRICARE covered abortions, and service member's rights to exercise their reproductive health rights.
- The attached Q&A document includes additional guidance on abortion care that DoD facilities can offer, TRICARE coverage, leave and travel policies for service members obtaining abortion care, and more.

August 2022 DoD Q&A Document

Contraceptive care

- Unless you are planning a pregnancy, you are highly encouraged to consider the range of contraceptive options available and covered under TRICARE (learn more through the Decide + Be Ready app) and discuss these options with your healthcare provider. Please also consider obtaining an emergency contraceptive pill (birth control you can use to prevent pregnancy after unprotected sex) for future use. Emergency contraceptive medication works better the sooner you take it after unprotected vaginal sex. It's a good idea to have it on hand **before you need it**. The DoD will continue to provide emergency contraceptive care in MTFs, consistent with federal law, regardless of state law restrictions.
- To learn more about available contraceptive methods, including emergency contraceptive methods, please click here. You can go to a Contraceptive Walk-In Clinic without an appointment to learn more about contraception and receive contraception the same day.

August 2022 Walk-In Clinic List

HELPFUL RESOURCES	LINK
Additional information on **abortion access in the military**	CLICK HERE
Live tracking of **abortion laws** across the **United States**	CLICK HERE
Live tracking of **abortion legality worldwide**	CLICK HERE
Miscarriage and Abortion **Clinician Support Hotline**	CLICK HERE
Reproductive Rights **Legal Hotline**	CLICK HERE
Pregnancy Options **Support Hotline**	CLICK HERE
Support for **financial and logistical access to abortion**	CLICK HERE
Contact for questions surrounding pregnancy in the Navy	Email ALTN_PregnancyandParenthood@navy.mil

RESOURCE LAST UPDATED 30 AUGUST 2022

Developed by: NAVY MEDICINE FEMALE FORCE READINESS CLINICAL COMMUNITY

For Service Members: Plan B® Patient Guide

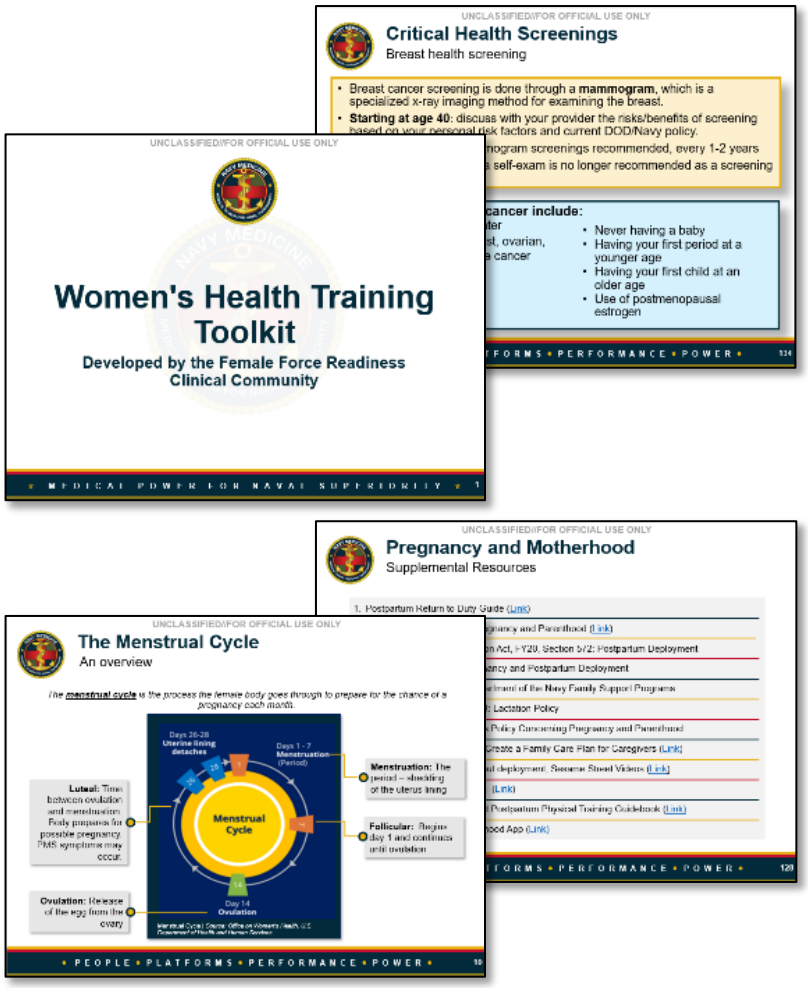
This resource provides information for service members on access to Plan B®, how the medication works, and additional emergency contraceptive options.

PLAN B® PATIENT GUIDE

- The What to Know: Accessing Plan B® resource highlights that service members can access Plan B® over the counter, at any military pharmacy.
  - Details how service members should take the medication after unprotected sex.
  - Describes alternative emergency contraception options available to service members including Copper Intrauterine Device (IUD), Hormonal IUDs, and ella®.
  - The Plan B® Patient Guide is available on the Women's Health Website.

For Providers: Women's Health Training Toolkit

A toolkit designed to enable operational medical personnel to host educational sessions on key women's health issues.



TRAINING TOOLKIT

- This toolkit includes **all components** that a unit's medical department would need to host an educational and engaging women's health training, including topics such as mental and sexual health.
- **Components** of the toolkit include:
  1. A training planning guide to support medical personnel preparing to host a training.
  2. Curriculum and associated presentation materials (i.e., PowerPoint slides for each module) designed to educate service members on women's healthcare.
  3. A facilitation guide to enhance the training experience to be more interactive.
- This Toolkit is available here on the **Women's Health Webpage.**

For Service Members: Postpartum Return to Duty Guide

Shares information on physical and emotional recovery after giving birth, support resources for military families, and other relevant information to support service members' return to active duty following childbirth.

POSTPARTUM RETURN TO DUTY TRANSITION GUIDE

- Provides service members with high-level information on how to safely and effectively return to duty following a pregnancy.
- The guide includes information on physical fitness and mental and physical health.
- Each section includes additional supporting resources (e.g., Navy and Marine Corps policies, relevant support services, and education resources) that are available for service members.
- This Guide is available here on the Women's Health Webpage.

For Service Members: Decide + Be Ready

An interactive way to learn about birth control options and the key considerations to help determine the best birth control option for each service member.

DECIDE + BE READY APP

- The Decide + Be Ready App explains the basics of different methods of contraception, including effectiveness, how it is used, and side effects.
- The App also offers a section on considerations for service members with information on menstrual management and how deployment may affect different forms of birth control.

Scan the QR code here to download the **Decide + Be Ready mobile app.**

References

1. Navy Medicine Women's Health Webpage – Abortion Care Handout (Link)
2. Navy Medicine Women's Health Webpage – Decide and Be Ready (Link)
3. Navy Medicine Women's Health Webpage – DRES Handbook (Link)
4. Navy Medicine Women's Health Webpage – Handout on Emergency Contraception (Link)
5. Navy Medicine Women's Health Webpage – Intimate Partner Violence (Link)
6. Navy Medicine Women's Health Webpage – Menstrual Suppression (Link)
7. Navy Medicine Women's Health Webpage – Navigating Infertility (Link)
8. Navy Medicine Women's Health Webpage – Normalizing Mental Healthcare (Link)
9. Navy Medicine Women's Health Webpage – Nutrition Guidelines and Recommendations (Link)
10. Navy Medicine Women's Health Webpage – Plan B® Patient Guide (Link)
11. Navy Medicine Women's Health Webpage – Postpartum Return to Duty Guide (Link)
12. Navy Medicine Women's Health Webpage – Recruit Contraception Fast Facts (Link)
13. Navy Medicine Women's Health Webpage – Relative Energy Deficiency in Sport (RED-S) (Link)
14. Navy Medicine Women's Health Webpage – Recovery from Early Pregnancy Loss (Link)
15. Navy Medicine Women's Health Webpage – Women's Health Education Guide (Link)
16. Navy Medicine Women's Health Webpage – Women's Health Training Toolkit (Link)
17. Navy Medicine Women's Health Webpage – 11 Provider Treatment Algorithms (Link)

Questions & Answer Session

Women's Health Seminar

Session 5: Women's Mental Health Considerations for Military Health Providers

CDR Heather Shibley, M.D.

Psychiatry Residency Program Director

Naval Medical Readiness Training Command; Portsmouth, VA

Presenter: CDR Heather Shibley

- CDR Heather Shibley, M.D.
- Psychiatry Residency Program Director
- Naval Medical Readiness Training Command
- Portsmouth, Virginia

Disclosures

- CDR Heather Shibley has no relevant financial or non-financial relationships to disclose relating to the content of this activity; or presenter(s) must disclose the type of affiliation/financial interest (e.g. employee, speaker, consultant, principal investigator, grant recipient) with company name(s) included.
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- Commercial support was not received for this activity.

Learning Objectives

LEARNING OBJECTIVES

- Review key elements for mental health disorder screening and assessing risk
- Overview of gender differences in mental health and highlighting common mental health diagnoses in women
- Discuss ‘baby blues’ vs. post-partum depression and mental health implications for pregnancy
- Discuss mental health stigma, medical management, and substance abuse

Screening for Mental Health Disorders

Overview

MENTAL HEALTH DISORDER SCREENING

- The US Preventive Services Task Force recommends screening for depression in all adults, including pregnant and postpartum women and screening for Intimate Partner Violence in all adult women.
- The Women's Preventive Service Initiative additionally recommends screening for Anxiety in all women.
- Validated screening questionnaires given in primary care settings can identify service members that benefit from intervention. **A positive screening tool does not always mean diagnosis but requires evaluation by a qualified healthcare professional.**

Photo | Source: USPSTF

Screening for Mental Health Disorders

Depression, Anxiety, and Postpartum Depression

Depression Screening

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(use "√" to indicate your answer)*

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, 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 _____

PHQ-9 Interpretation

Anxiety Screening

Patient Name: Jill Test
Address:
418 York Street, Fredericton NB E3B 3P7
Phone: 855-276-0513
Medicare No.: NB 922-700-208
Date of Birth: 28 Jan 1970

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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's 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
Add the score for each column	0	+ 0	+ 0	+ 0
Total Score *(add your column scores)* =		0		

If you checked off any problems, how difficult have these 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 ○

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

06 Jun 2017 9:07 AM; Test, Jill - HCN: 922700208 May contain confidential info Page 1 of 1

GAD-7 Interpretation

Postpartum Depression Screening

Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____
Your Date of Birth: _____
Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
☐ Yes, all the time
☒ Yes, most of the time This would mean: "I have felt happy most of the time" during the past week.
☐ No, not very often Please complete the other questions in the same way.
☐ No, not at all

In the past 7 days:

1. I have been able to laugh and see the funny side of things
☐ As much as I always could
☐ Not quite so much now
☐ Definitely not so much now
☐ Not at all

2. I have looked forward with enjoyment to things
☐ As much as I ever did
☐ Rather less than I used to
☐ Definitely less than I used to
☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
☐ Yes, most of the time
☐ Yes, some of the time
☐ Not very often
☐ No, never

4. I have been anxious or worried for no good reason
☐ No, not at all
☐ Hardly ever
☐ Yes, sometimes
☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
☐ Yes, quite a lot
☐ Yes, sometimes
☐ No, not much
☐ No, not at all

*6. Things have been getting on top of me
☐ Yes, most of the time I haven't been able to cope at all
☐ Yes, sometimes I haven't been coping as well as usual
☐ No, most of the time I have coped quite well
☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
☐ Yes, most of the time
☐ Yes, sometimes
☐ Not very often
☐ No, not at all

*8 I have felt sad or miserable
☐ Yes, most of the time
☐ Yes, quite often
☐ Not very often
☐ No, not at all

*9 I have been so unhappy that I have been crying
☐ Yes, most of the time
☐ Yes, quite often
☐ Only occasionally
☐ No, never

*10 The thought of harming myself has occurred to me
☐ Yes, quite often
☐ Sometimes
☐ Hardly ever
☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

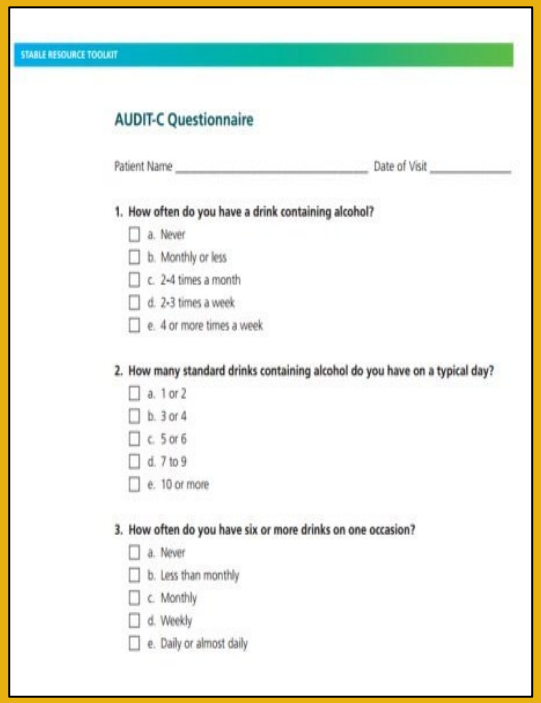
[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199

EPDS Interpretation

Screening for Mental Health Disorders

Alcohol Misuse, Post Traumatic Stress Disorder, Intimate Partner Violence

Alcohol Misuse



STABLE RESOURCE TOOLKIT

AUDIT-C Questionnaire

Patient Name _____ Date of Visit _____

1. How often do you have a drink containing alcohol?

- ☐ a. Never
- ☐ b. Monthly or less
- ☐ c. 2-4 times a month
- ☐ d. 2-3 times a week
- ☐ e. 4 or more times a week

2. How many standard drinks containing alcohol do you have on a typical day?

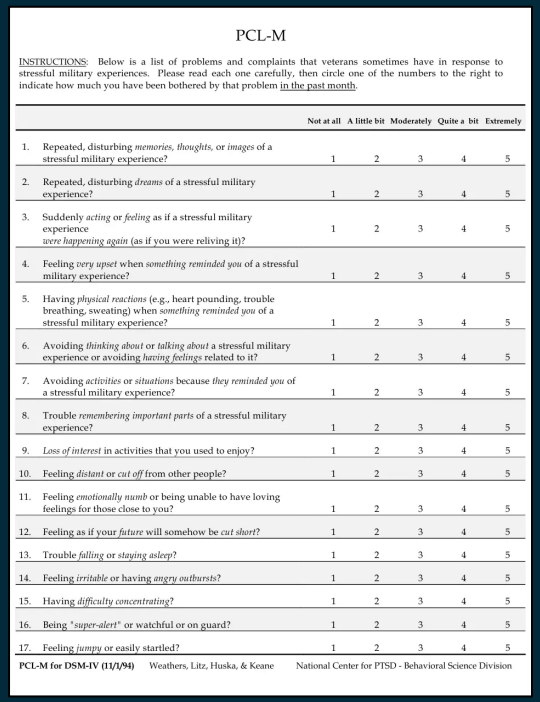
- ☐ a. 1 or 2
- ☐ b. 3 or 4
- ☐ c. 5 or 6
- ☐ d. 7 to 9
- ☐ e. 10 or more

3. How often do you have six or more drinks on one occasion?

- ☐ a. Never
- ☐ b. Less than monthly
- ☐ c. Monthly
- ☐ d. Weekly
- ☐ e. Daily or almost daily

AUDIT-C Interpretation

Post Traumatic Stress Disorder



PCL-M

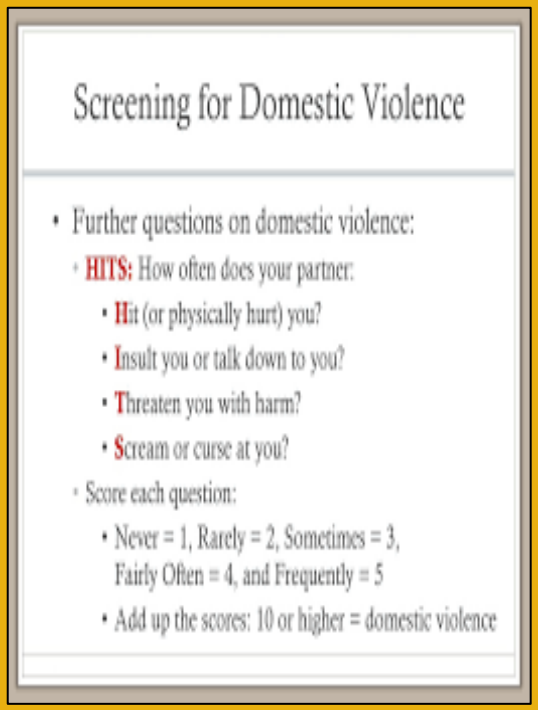
INSTRUCTIONS: Below is a list of problems and complaints that veterans sometimes have in response to stressful military experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

		Not at all	A little bit	Moderately	Quite a bit	Extremely
1.	Repeated, disturbing *memories, thoughts,* or *images* of a stressful military experience?	1	2	3	4	5
2.	Repeated, disturbing *dreams* of a stressful military experience?	1	2	3	4	5
3.	Suddenly *acting* or *feeling* as if a stressful military experience *were happening again* (as if you were reliving it)?	1	2	3	4	5
4.	Feeling *very upset* when *something reminded you* of a stressful military experience?	1	2	3	4	5
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful military experience?	1	2	3	4	5
6.	Avoiding *thinking about* or *talking about* a stressful military experience or avoiding *having feelings* related to it?	1	2	3	4	5
7.	Avoiding *activities* or *situations* because *they reminded you* of a stressful military experience?	1	2	3	4	5
8.	Trouble *remembering important parts* of a stressful military experience?	1	2	3	4	5
9.	*Loss of interest* in activities that you used to enjoy?	1	2	3	4	5
10.	Feeling *distant* or *cut off* from other people?	1	2	3	4	5
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?	1	2	3	4	5
12.	Feeling as if your *future* will somehow be *cut short*?	1	2	3	4	5
13.	Trouble *falling* or *staying asleep*?	1	2	3	4	5
14.	Feeling *irritable* or having *angry outbursts*?	1	2	3	4	5
15.	Having *difficulty concentrating*?	1	2	3	4	5
16.	Being "*super-alert*" or watchful or on guard?	1	2	3	4	5
17.	Feeling *jumpy* or easily startled?	1	2	3	4	5

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

PCL-M Interpretation

Intimate Partner Violence



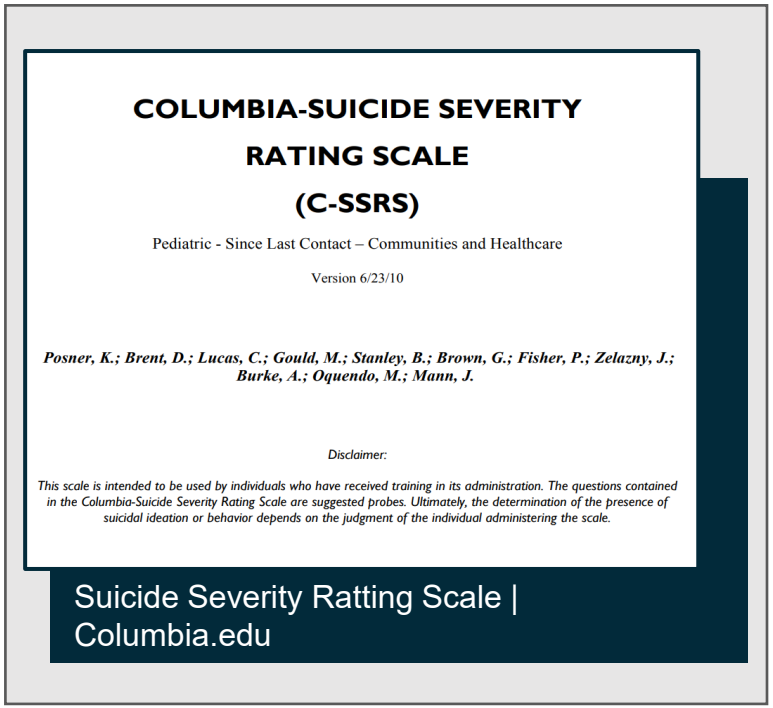
Screening for Domestic Violence

- Further questions on domestic violence:
  - HITS: How often does your partner:
    - Hit (or physically hurt) you?
    - Insult you or talk down to you?
    - Threaten you with harm?
    - Scream or curse at you?
  - Score each question:
    - Never = 1, Rarely = 2, Sometimes = 3, Fairly Often = 4, and Frequently = 5
    - Add up the scores: 10 or higher = domestic violence

Assessing Risk
Overview

ASSESSING RISK

- **Risk of harm** to self or others is instrumental to determining safe disposition for service members and should be assessed with every patient.
- **Screening tools** such as the GriST or Columbia Suicide Severity Rating Scale may be helpful to determine risk of self harm, but direct questions such as “Do you have a plan to take your life?” can also be used to determine risk.
- The risk of **violence against others** should also be assessed. You may assess this with questions or use screening tools such as VIO-SCAN.
- Individuals who you determine to be **high acute risk** for self harm or violence against others should be referred immediately to a qualified mental health provider.


COLUMBIA-SUICIDE SEVERITY
RATING SCALE
(C-SSRS)
Pediatric - Since Last Contact – Communities and Healthcare
Version 6/23/10
Posner, K.; Brent, D.; Lucas, C.; Gould, M.; Stanley, B.; Brown, G.; Fisher, P.; Zelazny, J.; Burke, A.; Oquendo, M.; Mann, J.
Disclaimer:
This scale is intended to be used by individuals who have received training in its administration. The questions contained in the Columbia-Suicide Severity Rating Scale are suggested probes. Ultimately, the determination of the presence of suicidal ideation or behavior depends on the judgment of the individual administering the scale.

Suicide Severity Ratting Scale | Columbia.edu

Gender Differences and Mental Health

Overview

GENDER DIFFERENCES

- Mental illnesses are **among the most common health conditions** in the United States.
  - Per the CDC, more than **50% of people** will be diagnosed with a mental illness or disorder at some point in their lifetime.
  - Overall prevalence for women is **22.3%.**
- **18% of the total force is female** – Military experiences of women and their responses to those experiences are different from their male counterparts.
- Incident rates of **mental health diagnoses were higher among females than males** for adjustment disorders, anxiety disorders, PTSD, and depressive disorders.

Photo | Source: phys.org

Common Diagnoses in Women

Anxiety, Depression, Personality Disorders, Eating Disorders, etc.

COMMON DIAGNOSES

- Two most common categories in women – **anxiety and depression**
  - Per CDC, **1 in 10 women** in the United States reported symptoms suggestive of an episode of major depression in the last year.
- **Adjustment** and **personality disorders** were more than twice as often diagnosed in active duty service women compared to active duty men.
- The incidence of eating disorders is over **20 times** higher in female active duty service members than in male.
- Results from female veteran studies show a significant predictive relationship between **deployment-related traumatic stressors**, most notably combat experiences and sexual assault and sexual harassment, and PTSD outcomes.

Mental Health Disorders Unique to Females

Hormone – Related Disorders

Hormones can affect a woman's emotions and moods in different ways throughout her lifetime. Mental disorders at times of hormone change include:

PERINATAL DEPRESSION

- Includes both the prenatal and postpartum periods, is estimated to be as high as 24 percent in female service members.
- The highest prevalence of symptoms (16.6 percent) was found in female service members who had deployed after childbirth and who experienced combat exposure.

PREMENSTRUAL DYSPHORIC DISORDER (PMDD)

- PMDD is a condition similar to PMS but with more severe symptoms, including severe depression, irritability, and tension and may impact daily life.
- PMDD is more common in women with anxiety or depression.

PERIMENOPAUSE-RELATED DEPRESSION

- Women with mental health conditions may experience more symptoms of menopause or go through perimenopause differently than women who do not have mental health conditions.

Mental Health Disorders Unique to Female

Baby Blues vs. Postpartum Depression

POSTPARTUM DEPRESSION includes symptoms of depression that occur after having a baby; feelings are more intense and last longer than "baby blues" (typically most days, for a period longer than two weeks).

"BABY BLUES" describes worry, sadness and tiredness many women experience after having a baby and resolves within a few days.

1 in 8 women may experience symptoms of postpartum. depression.
Experiences that may put some women at a higher risk for depression can include:

- Stressful life events
- Low social support
- Previous history of depression
- Family history of depression
- Difficulty getting pregnant
- Being a mom to multiples
- Preterm labor and delivery
- Pregnancy and birth complications

Mental Health Impact on Pregnancy

Eating Disorders, Bipolar Disorder, Anxiety

EATING DISORDERS, BIPOLAR DISORDER, ANXIETY

Eating Disorders

- Women with eating disorders may experience relapses during pregnancy, which can cause miscarriage, premature birth (birth before 37 weeks of pregnancy), and low birth weight.

Bipolar Disorder

- Women may experience relief from symptoms of bipolar disorder during pregnancy.
- High risk of a relapse of symptoms in the weeks after pregnancy.

Anxiety

- Women with anxiety disorders and obsessive-compulsive disorder (OCD) are more likely to have a relapse during and after pregnancy.

Photo | Source: womenshealth.org

Reproductive Health

Pregnancy and Mental Health

EATING DISORDERS, BIPOLAR DISORDER, ANXIETY

- Can have lasting impact on **mental health**.
- Mental health conditions affect **10%** of pregnant women worldwide.
- Women with early pregnancy loss (miscarriage) 16% showed signs of PTSD and 17% with signs of anxiety 9 months after pregnancy loss.
- Women undergoing infertility treatments have higher levels of anxiety and depression and lower reported quality of life.
- Intrapartum/Postpartum depression can have lasting effects on maternal and infant health, if untreated.
- Reproductive health can be a particularly challenging topic for women in the military – offering early services may be beneficial.

Photo | Source: army.mil

Stigma and Mental Health

Stigma of Seeking Help and Reducing Stigma

MENTAL HEALTH STIGMA

STIGMA OF SEEKING HELP:

- Wanting to fix things themselves.
- Concern for labels such as “being weak” – may be more present in commands with fewer females due to not wanting to be “singled out.”
- Worried about impact to their career or security clearance
- Fear gossip or embarrassment.

REDUCING STIGMA:

- Maintain the privacy and confidentiality of those seeking mental healthcare.
- Correcting negative language that can cause stigma.
- Sending the message that mental health care can be a routine and integral part of overall healthcare.
- Communicating the message that seeking help early prevents needing a higher level of care and impact to career.

Photo | Source: womenshealth.org

Mental Health Road Map

Overview

Chaplains – 100% confidential, no reporting requirement, no health record documentation.

Military and Family Life Counseling – Non-medical counseling and classes, flexible hours and locations, no health record documentation.

Fleet and Family Support Center – Non-medical individual counseling and life skills (financial, stress, coping skills), couples counseling.

Military OneSource – Non-medical counseling off-base, flexible hours, no health record documentation.

IDC/SMO (Your Command "Doc") – Places referral to EMH/MTF/Network for more serious conditions or duty determinations; medication management for most mental health concerns.

Embedded Mental Health (EMH) – Mental health specialists supporting your command, can provide military duty determinations.

Military Treatment Facilities (MTF) – Includes specialty mental health, emergency room and inpatient psychiatry; Internal Behavioral Health Consultants in Primary Care.

Network – Must have referral for Tricare coverage, cannot make duty determination.

Emergency Room – Danger to self, others or gravely disabled. Not for routine access to care.

When Specialty Mental Health Services are Needed

Overview

SPECIALTY SERVICES NEEDED

- When there is a concern about **duty status.**
- Acute, imminent **safety concerns to self** or others.
- Other services have been used with **no improvement** – if no concern about acute SI/HI or duty status, try other resources first (i.e. IBHC, MFLC, Military OneSource).

Medication Management

- **Medication** may be an important part of management of symptoms for mental health disorders.
- **Primary Care Provider**
  - Up to 70% of primary care visits are driven by psychological problems.
  - Many primary care physicians can prescribe initial treatment for depression, anxiety, ADHD and many other mental health disorders.
- **Psychiatrist**
  - May be consulted by primary care physician in severe cases or if initial treatments do not help to manage symptoms.
- **All medical providers** can work in conjunction with all non-pharmacologic management (i.e., therapy).

Photo | Source: jhu.edu

Substance Abuse Screening Process

Referring Patients

Types of referrals
- Self-referrals
- Command referrals (i.e. alcohol related incidents, positive urinalysis for illicit drugs)
- Medical referrals

How to refer
- Service members should meet with their DAPA (USN)/SACO (USMC) to complete initial screening
- Self-referral may be made directly to screening in certain circumstances.

Process
- Once screened by DAPA/SACO, member will be referred to prospective substance abuse program (SARP (USN)/SACC (USMC)) for evaluation.
  - Note: SARP is medical and documents in the EMR; SACC is non-medical and does not document in the EMR.
- Patient will be referred for treatment, if indicated.

Photo | Source: sutterhealth.org

ASAM Criteria

What is The ASAM Criteria?

- Comprehensive set of guidelines for placement, continued stay, transfer or discharge of patients with addiction.

The six dimensions of ASAM Criteria include:

- **Acute intoxication and/or withdrawal potential** – past and current experiences of substance use and withdrawal.
- **Biomedical conditions and complications** – individual's health history and physical health needs.
- **Emotional, behavioral or cognitive conditions and complications** – mental health history and needs.
- **Readiness to change** – an individual's readiness and interest in changing.
- **Relapse, continued use or continued problem potential** – risk for relapse.
- **Recovering/living environment** – the people and places that can support or hinder recovery.

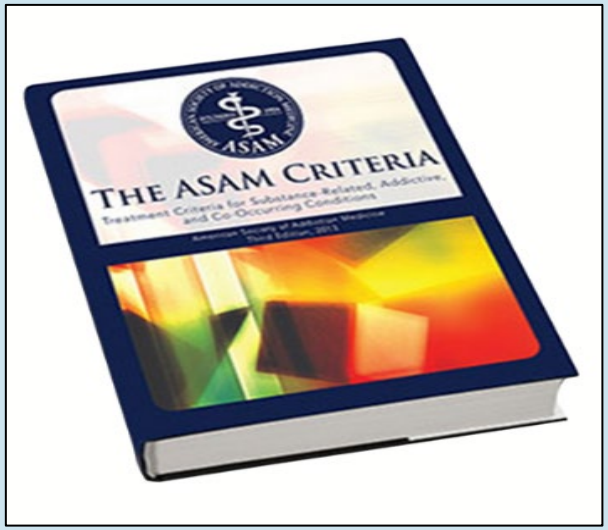


Photo | Source: ASAM Criteria

Level of Substance Abuse Treatment

Treatment recommendations may include:

- Level 0.5 Prevention/Early Intervention
- Level 1 Outpatient Program
- Level 2 Intensive Outpatient
- Level 3 Residential Treatment
- Level 4 Medically Managed Intensive Inpatient Services

About the ASAM Criteria

Other Considerations

Operational Settings

- Psychiatric conditions consistently rank among top 3 reasons for evacuation from theater over last 10 years.

Navy and Marine Corps

- Follow MANMED Chapter 15 regarding deployment health and fitness for duty standards including mental health conditions.
- Existing mental health problems are screened prior to deployments (DD 2795) and operational duties (NAVMED 1300/1).
- Patients must be deemed by their provider to have no conditions interfering with their duties to be fit for operational duty.
- A member may not be deployed within 3 months of starting a psychotropic medication – after 3 months a waiver may be considered.

https://www.med.navy.mil/Directives/MANMED/

Other Considerations

Sexual Assault

- In 2021, 35,900 active duty service members experience some form of unwanted sexual contact – a 13% increase from prior years.
- Sexual assault victims show increased rates of depression, PTSD, sexual dysfunction and dyspareunia.
- Service members may present in various ways or times following an assault to seek mental health services – can be immediate or years later.
- Patients confiding in medical professionals may still pursue Restricted Reporting of their assault – if providers are unsure, they should contact the local victims advocate, do **NOT** discuss with the soldier or sailor's chain of command!

DOD SAFE Helpline
877-995-5247
Confidential DOD sexual assault support
24/7, worldwide.

National Sexual Assault Hotline
1-800-656-4673
24/7, US only

https://sapr.mil/

References

1. CDC – Mental Health (Link)
2. Health.mil – Women's Mental Health (Link)
3. Mayo Clinic – Postpartum Depression (Link)
4. MGH Center – Women's Mental Health (Link)
5. Phys.org - Military Gender Equality (Link)
6. Pregnancy and Childbirth – A Guide to Prenatal Care (Link)
7. RAND – Research Reports (Link)

Questions & Answer Session

Women's Health Seminar

Session 6: Transgender Healthcare In The Military

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Transgender Care Team (TGCT) Primary Care Subject Matter Expert (SME)

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Disclosures

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Learning Objectives

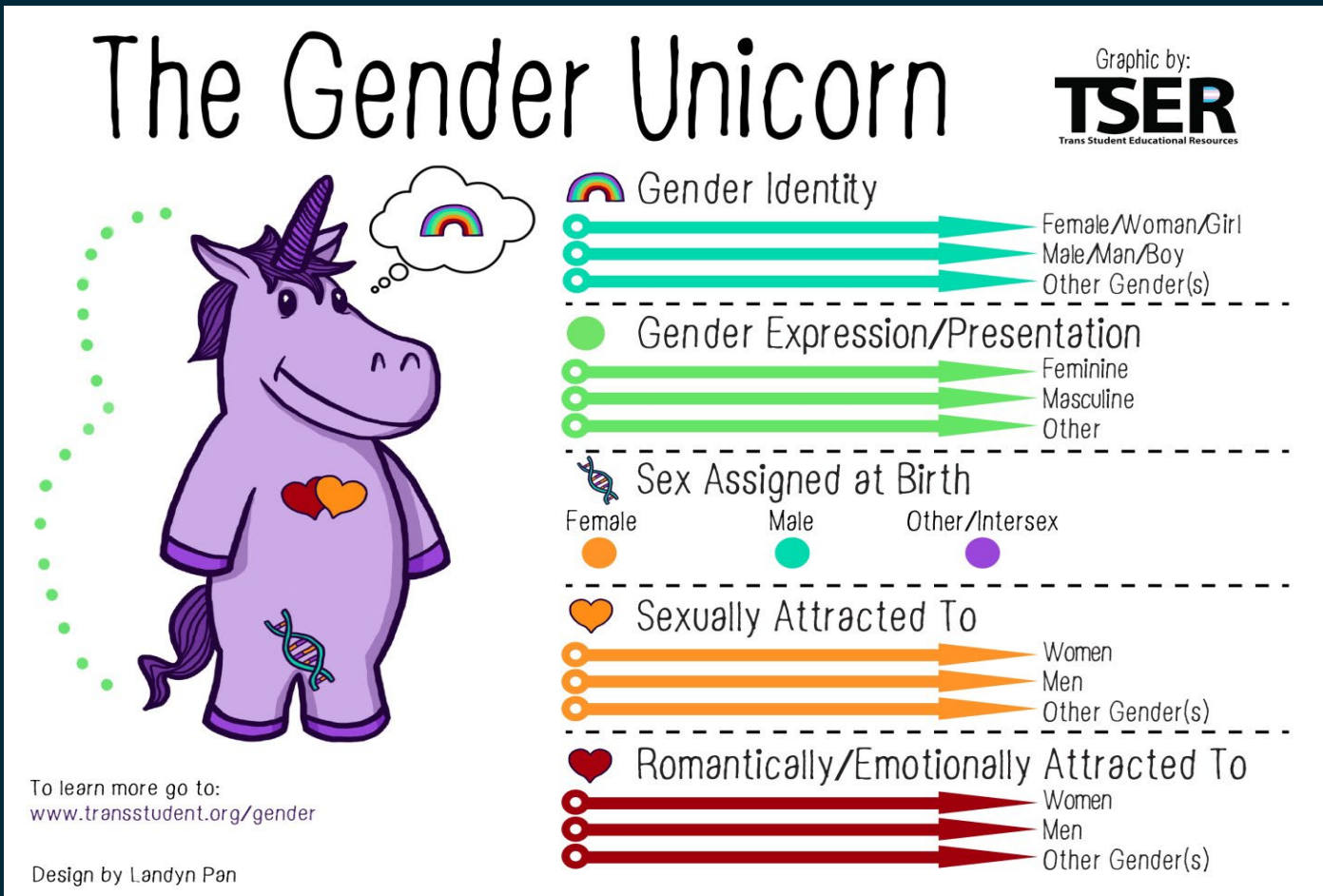
LEARNING OBJECTIVES

- Discuss terminology and primary care for transgender patients
- Discuss key policies and pathways in care of transgender service members
- Discuss the care team and the transgender medical treatment plan
- Discuss potential role of primary and operational medicine in transgender healthcare
- Review medical and surgical treatment options

The Many Parts of Your Patient

Many Parts of Your Patient

The Gender Unicorn



Gender Unicorn | Source: tser.org

Many Parts of Your Patient

Gender – Inclusive Language

Gender-inclusive language for sexual and reproductive health care

Current practice	Suggested alternative
Language	
Women's health care (providers, services, clinic, etc)	Sexual and reproductive care
Well-woman examination	Annual examination, well-person examination, or Papanicolaou smear, pelvic examination
Breast-feeding	Breast- or chest-feeding
Mother	Parent or gestational parent
Intake forms, EMRs, and history taking	
Address all patients as Ms or Mrs	Call patients in from the waiting room by last name only. Ask all patients: "How would you like me to address you?"
Questions about menstrual and obstetric history	Avoid assumptions about anatomy. Clarify whether the patient has a uterus. This is also more friendly for cis-gender women who have had a hysterectomy and for intersex people.
Sexual history: "Are you sexually active with men, women, or both?"	"Who do you have sex with?" "What anatomy (parts) do they have?" followed by appropriate questions regarding specific sexual practices, as needed
"Are you sexually active?"	Acknowledge that there are many sexual practices that do not include penile-vaginal penetration. "Have you ever been sexually intimate in a way that included exchange of genital body fluids?" "Do you have oral or anal sex?" "Have you ever had vaginal (or front) penetration with a penis, finger, or toy?"
Sex marker: binary options (male or female)	Many EMRs now offer a preferred name and pronoun field.
	Use a 2-step gender question: (1) what is your gender? Enable more than 2 options for people who identify as nonbinary, queer, or other; (2) what sex were you assigned at birth (ie, on your original birth certificate)?[18]
Visual cues	
Bathroom signage: men/women	Ensure at least 1 single-stall, nongender (or all-gender) bathroom that is accessible and easily identifiable

EMR, electronic medical record.

Stroumsa. Expanding the language of "women's health." Am J Obstet Gynecol 2018.

Epidemiology

Epidemiology
Gender Statistics

STATISTICS

- **1.5 million** in U.S. identify as transgender.
- **0.6%** experience gender dysphoria worldwide.
- **39%** with significant psychological distress.
- **40%** attempt suicide.
- Increased unemployment, poverty, homelessness, uninsured.
- Clinical setting:
  - **19%** refused care.
  - **28%** harassed.
  - Concern for pain and dysphoria lead to **delays in care**.

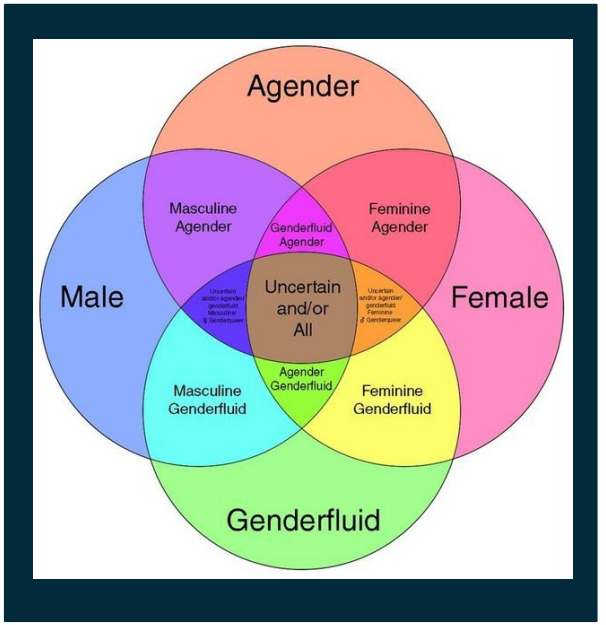
Photo | Source: *consumerreports.org*

Epidemiology
Gender Terminology

Terms used to describe various aspects of gender and sexuality*

Gender identity	An individual's innate sense of feeling male, female, neither, or some combination of both.
Natal or birth-assigned/birth-designated sex	Typically assigned/designated according to external genitalia or chromosomes.
Gender expression	How gender is presented to the outside world (eg, feminine, masculine, androgynous); gender expression does not necessarily correlate with birth-designated sex or gender identity.
Gender diversity	Variation from the cultural norm in gender identity, expression, or gender role behavior (eg, in choices of toys, playmates); "gender diversity" acknowledges the spectrum of gender identities and replaces "gender nonconformity," which has negative and exclusionary connotations.
"Transgender" ("trans" as an abbreviation)	Umbrella term that is used to describe individuals with gender diversity; it includes individuals whose gender identity is different from their birth-designated sex and/or whose gender expression does not fall within stereotypical definitions of masculinity and femininity; "transgender" is used as an adjective ("transgender people"), not a noun ("transgenders").
Gender dysphoria or incongruence	Distress or discomfort that may occur when gender identity and birth-designated sex are not completely congruent.
Transsexual	Older, clinical term that has fallen out of favor; historically, it was used to refer to transgender people who sought medical or surgical interventions for gender affirmation.
Sexual orientation	An individual's pattern of physical and emotional arousal (including fantasies, activities, and behaviors) and the gender(s) of persons to whom an individual is physically or sexually attracted (gay/lesbian, straight, bisexual); sexual orientation is an entirely different construct than gender identity, but is often confused with it; the sexual orientation of transgender people is based upon their identified gender (eg, a transgender man who is attracted to other men might identify as a gay man; a transgender woman who is attracted to other women might identify as a lesbian).
Sexual behaviors	Specific behaviors involving sexual activities that are useful for screening and risk assessment; many youth reject traditional labeling (homosexual, heterosexual, bisexual) but still have same-sex partners.
Transgender man/transman/transmasculine person	Person with a masculine gender identity who was designated a female sex at birth.
Transgender woman/transwoman/transfeminine person	Person with a feminine gender identity who was designated a male sex at birth.
Nonbinary gender identity	Person of any birth-designated sex who has a gender identity that is neither masculine nor feminine, is some combination of the two, or is fluid. Other terms that may be used for nonbinary gender identity include genderqueer, gender creative, gender independent, bigender, noncisgender, agender, two-spirit, third sex, and gender blender.

* These are cultural and descriptive terms, not diagnostic terms, which are specific to medical and pathology-based paradigms.



Gender Affirming Care

Gender Affirming Care

The Clinical Setting

IDENTIFICATIONS

- Ask **pronouns**
- Support patient **identity**
- **Mistakes** happen

CLINICAL ENVIRONMENT

- **Generic** terms
- Staff education
- **All-gender** restrooms

ENCOUNTERS

- Do not be **probing**
- Ensure **specific needs** are addressed
- Consider **relevance of examination**

Photo | Source: phys.org

Gender Affirming Care

Transmen and Transwomen

Transmen

- Pap screening
  - Perform as usual.
  - Be mindful.
  - More likely inadequate.
- Breast tissue screening
  - Same for average females without mastectomy.
  - With mastectomy, US/MRI and consider annual chest exam.

Transwomen

- Breast tissue screening – mammogram
  - Start 5-10 years after exogenous estrogens in transwomen q2 years
  - > 50 years typical screening
- Prostrate screening
- Consider neovaginal exams for squamous lesions

Preventative Care

Sexual Health Risk Assessment, STI Screening, Contraceptive Counseling

PREVENTATIVE CARE

- **Sexual Health Risk Assessment**
  - Consider distinct language.
  - Consider using the patients' language.
  - No assumptions.
- **STI Screening**
  - HIV prevalence 14% of transwomen (44% black).
  - PreP assessment.
  - High risk – q3 month screens (annual HIV, Syphilis, GC/CT urine, rectal, pharyngeal; HCV if HIV +)
- **Contraception Counseling**
  - Hormone therapy is not contraception.
  - Testosterone – Low birth weight, fetal masculinization.
  - Consider progestins.

DoD Transgender Policy Changes

Policy Changes from 2015 – 2022

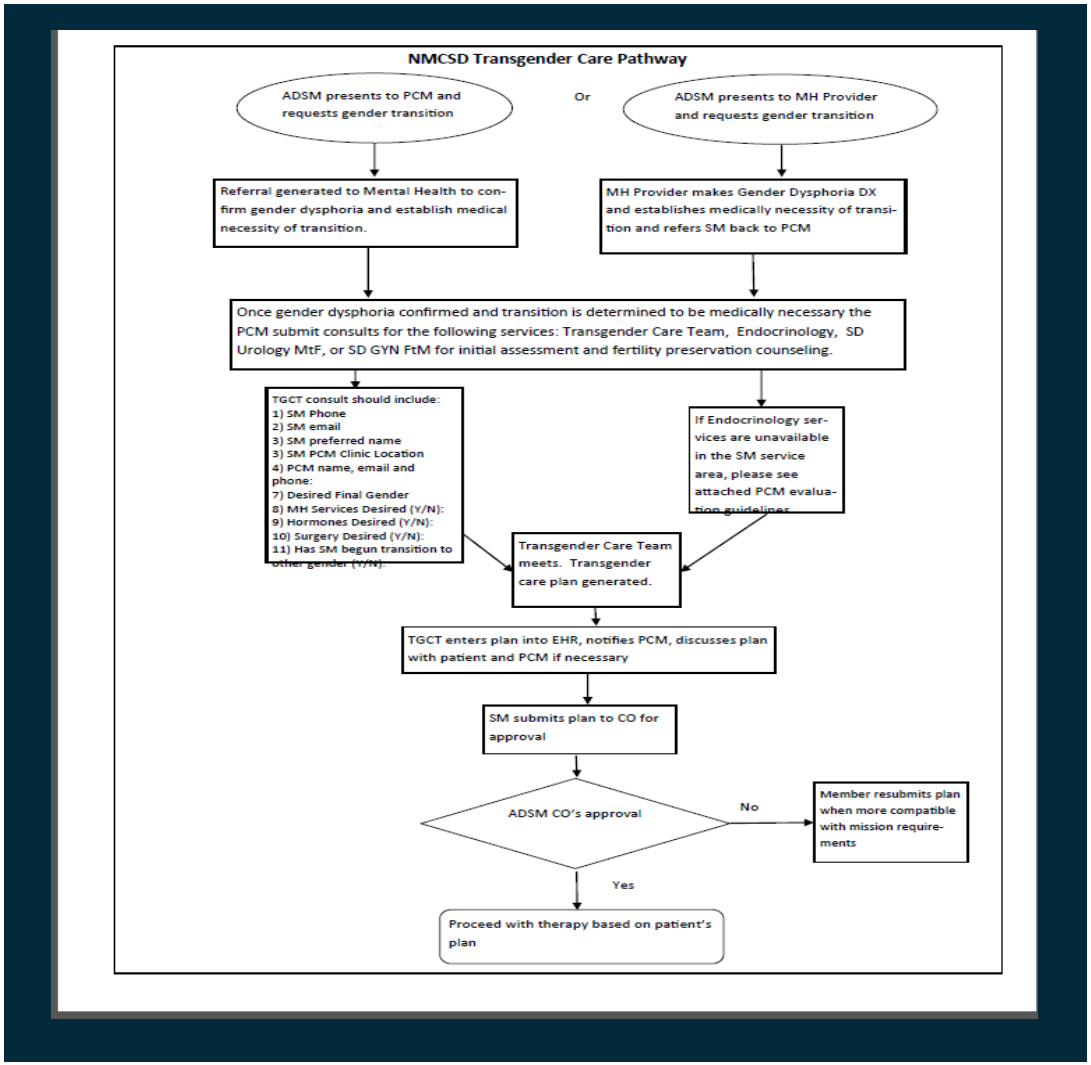
DoD Trangender Policies 2015 - 2022

- **July 2015** – Secretary of Defense directed the Department of Defense to identify the practical issues related to open service of transgender Americans serving openly and to develop an implementation plan that address those issues consistent with military readiness.
- **June 30, 2016** – Secretary of Defense announced a new policy allowing open service of transgender service members
- **April 30, 2021** – Policy update that restored original 2016 policies for service for transgender service members
- **November 2022** – Updated DODI released.

Photo | Source: defense.gov

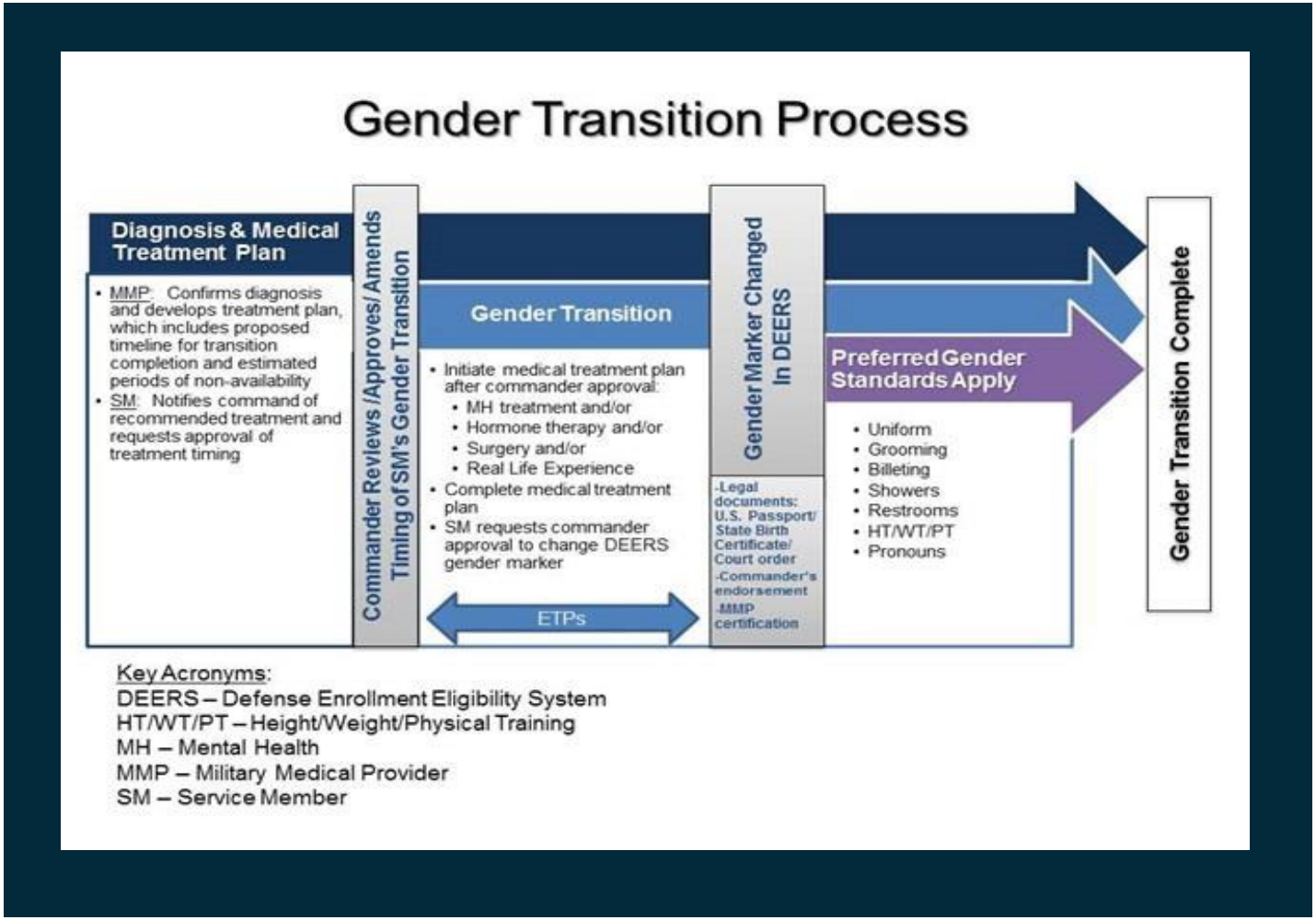
Transgender Care Pathway

Naval Medical Forces Pacific Transgender (NMFP) Care Team (TGCT)



Gender Transition Process

Diagnosis & Medical Treatment Plan



Members of Transgender Care Team

Team Member Positions

Transgender Care Team Members

- Chair
- Case Manager
- Administration Office – TGCT Point of Contact
- Endocrinology SME
- Primary Care SME
- OB/GYN SME
- Psychiatry SME
- Psychology SME
- Urology SME
- Plastic Surgery SME
- IDC representatives
- NMFP/NMFA representative

Responsibilities of Service Members, Commanding Officers, and Military Medical Providers

Service Member Responsibilities
Overview

SERVICE MEMBER RESPONSIBILITIES

- Secure a **medical diagnosis** from military medical provider.
- **Route Medical Treatment Plan** for Commanding Officer (CO) for approval.
- **Notify CO** of diagnosis for medically necessary gender transition
  - All treatment and schedule of treatment including date of gender marker change in **DEERS** to be outlined.
- **Notify CO of any changes to medical treatment plan**, schedule for treatment, or estimated date of gender marker change.
- **Notify CO of any new care deemed medically necessary** after a gender marker change in DEERS that was not in previously approved medical treatment plan.

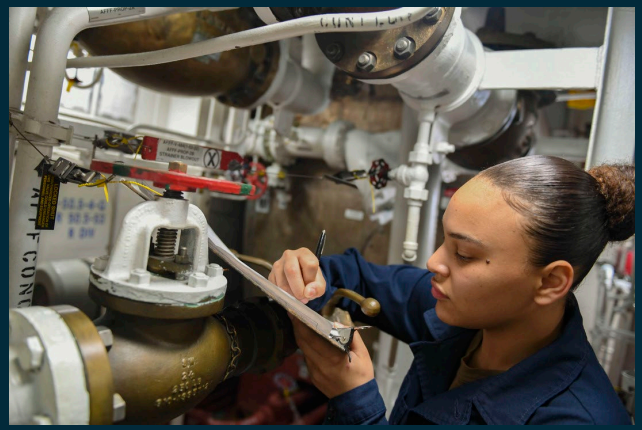


Photo | Source: defense.gov

Commanding Officer (CO) Responsibilities

Overview

CO RESPONSIBILITIES

- **Review and approve** service member's request to transition and timing.
- Oversees that **transition process**:
  - **Complies** with regulations, policies, and guidance.
  - **Considers** facts and circumstances of the respective service member.
  - **Maintains** military readiness by minimizing impact to mission, morale, welfare, good order, and discipline of the unit.
  - **Consistent** to medical treatment plan.
- Coordinate with **military medical provider** regarding any care or medical issues that may arise.
- Consult, as necessary, with the **SCCC**.

Photo | Source: defense.gov

Military Medical Provider's Responsibilities

Overview

PROVIDER RESPONSIBILITIES

- Establish **medical diagnosis**.
- Recommend **medically necessary care and treatments**.
- **Advise CO** on medical diagnose, necessary care and treatment, urgency of proposed treatment, and impact of plan on readiness and deployability.
- **Formally advise the CO** when transition is complete and recommend time for gender marker change in DEERS.
- **Provide** any medically necessary care after gender marker change.

Photo | Source: defense.gov

Roles of Primary Care in Transition

Managing, Referring, Assisting with Document Transition

PRIMARY CARE ROLE IN TRANSITION

- **Primary Care Provider**
  - Preventative Healthcare (Organ Inventory for screening, PreP consideration).
  - Discussing fertility desires (Contraception, prenatal counseling, gamete preservation).
  - Pathway often starts with PCM and ends with PCM.
- **Managing Gender Affirming Hormone Therapy**
  - With specialist involvement, if necessary.
  - LIMDU.
- **Referring to Specialty Providers.**
  - OB/GYN, Surgery, Mental Health, Reproductive Endocrinology/Infertility.
- **Assisting with Transition in Documents.**
  - Working with MD.DO/Psy D for completion of documents for civilian gender change.
  - Input with CO for DEERS gender change.

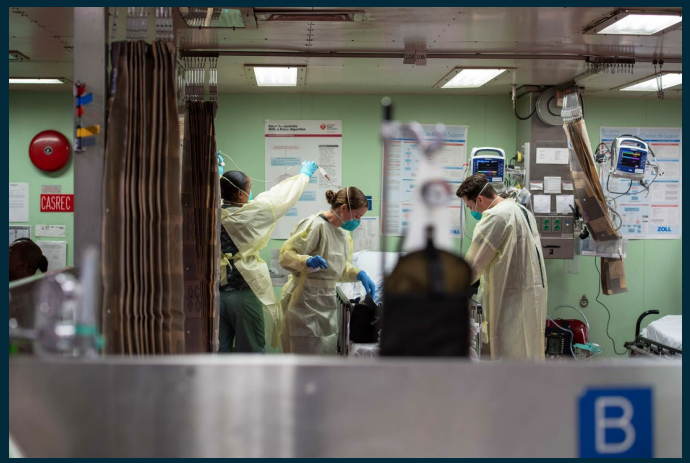


Photo | Source: defense.gov

Consult from Providers

Mental Health, Endocrinology, Fertility Preservation, Gender Affirming Care

CONSULT FROM PROVIDERS

- Patient will **need referrals** to several specialists prior to drafting of TGCT medical treatment plan
  - **Mental Health**: Diagnosis of Gender Dysphoria must be documented or validated by a military mental health provider
  - **Endocrinology/ Hormone** Therapy Counseling
  - **Fertility Preservation** Counseling (+/-)
  - Feminizing **gender affirming** care: PCM or Urology
  - Masculinizing **gender affirming** care: PCM or GYN

Photo | Source: defense.gov

Initial Stages

Initial Consult from PCM to TGCT

Components of Consult to TGCT

CONSULTS TO TGCT SHOULD INCLUDE:

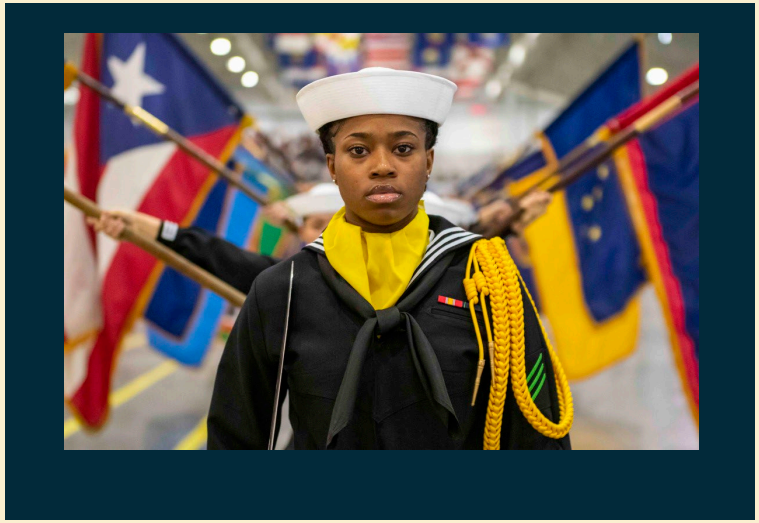
- SM Phone
- SM email
- SM preferred name & pronouns
- PCM name, email and phone
- Desired Final Gender Marker
- MH Services Desired (Y/N)
- Hormones Desired (Y/N)
- Surgery Desired (Y/N)
- Has SM begun transition to other gender (Y/N) – If Yes, what treatments (LE, Surgery, Hormones, MH treatment)
- Must be documented or validated by a military mental health provider

Initial Visits

Components of an Initial Visit

INITIAL VISIT

- Review history of **gender experience**
- Document prior **hormone use**
- Obtain **sexual history**
- Review **patient goals**
- Address **safety concerns**
- Assess **social support system**
- Assess **readiness** for gender affirming care
- Review **risks and benefits** of hormone therapy
- Obtain **informed consent**
- Order **screening laboratory studies**
- Provide **referrals**



Follow Up Visits

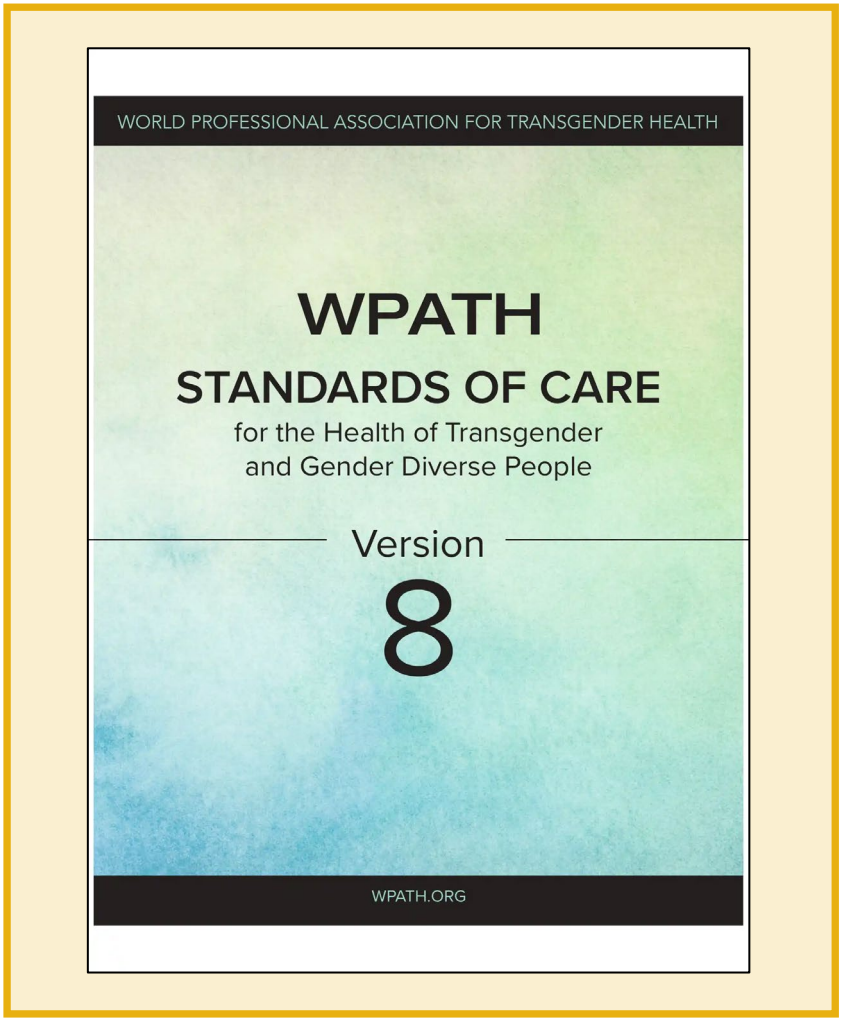
Components of a Follow Up Visit

FOLLOW UP VISIT

- **Assess response** to masculinization or feminization hormone therapy
- **Review medication** use
- **Monitor mood** and adjust medication as indicated.
- Discuss **social impact of transition**
- Counsel regarding **sexual activity**
- Review **surgical options**
- Review plan to **change name and gender marker** on legal forms
- Assess **safety**

Main Guidelines

World Professional Association for Transgender Health (WPATH)



Diagnosis of Gender Dysphoria

DSM-5-TR Criteria

GENDER DYSPHORIA IN ADOLESCENTS AND ADULTS (F64.0):

A marked incongruence between one's experienced/expressed gender and assigned gender, of at least 6 months' duration, as manifested by at least two of the following:

- A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or in young adolescents, the anticipated secondary sex characteristics).
- A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
- A strong desire for the primary and/or secondary sex characteristics of the other gender.
- A strong desire to be of the other gender (or some alternative gender different from one's assigned gender).
- A strong desire to be treated as the other gender (or some alternative gender different from one's assigned gender).
- A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's assigned gender).
- The condition is associated with clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Diagnosis of Gender Dysphoria

DSM-5-TR Criteria

Specify if:

- With a disorder/difference of sex development (e.g. a congenital adrenogenital disorder such as E25.0 congenital adrenal hyperplasia or E34.50 androgen insensitivity syndrome).
- Coding note: Code the disorder/difference of sex development as well as gender dysphoria.

Specify if:

- Post-transition: The individual has transitioned to full-time living in the experienced gender (with or without legalization of gender change) and has undergone (or is preparing to have) at least one gender-affirming medical procedure or treatment regimen – namely, regular gender-affirming hormone treatment or gender reassignment surgery confirming the experienced gender (e.g. breast augmentation surgery and/or vulvovaginoplasty in an individual assigned male at birth; transmasculine chest surgery and/or phalloplasty or metoidioplasty in an individual assigned female at birth).

Gender Identity Disorders

ICD-10 Criteria

F64.0Transsexualism

A desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with, or inappropriateness of, one's anatomic sex, a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex.

F64.2 Gender identity disorder of childhood

A disorder, usually first manifest during early childhood (and always well before puberty), characterized by a persistent and intense distress about assigned sex, together with a desire to be (or insistence that one is) of the other sex. There is a persistent preoccupation with the dress and activities of the opposite sex and repudiation of the individual's own sex. The diagnosis requires a profound disturbance of the normal gender identity; mere tomboyishness in girls or girlish behaviour in boys is not sufficient. Gender identity disorders in individuals who have reached or are entering puberty should not be classified here but in F66.-.

Excluding:

Egodystonic sexual orientation (F66.1)

Sexual maturation disorder (F66.0)

F64.8 Other gender identity disorders

F64.9 Gender identity disorder, unspecified

Gender-role disorder NOS

Key Portions of TGCT Care Plan

Mental Health, Medical, Surgical, Exception to Policy

TGCT CARE PLAN

- **CO** address and purpose.
- **Mental Health**
  - Military Diagnosing provider and date.
  - Statement on necessity of care.
  - Plan for follow up care.
- **Medical**
  - Provider evaluating patient.
  - Clearance for initiation of CSHT.
- **Surgical**
  - Medically necessary surgeries planned.
  - Non-medically necessary surgeries desired.
- **Exception to Policy**
  - To be routed by patient through admin.
- **DEERS** Gender Marker Change.
- **Anticipated completion date.**

Medical Gender Affirming Care

WPATH Criteria for Hormones

Criteria for Adults

CRITERIA FOR HORMONES

- **Gender incongruence** is marked and sustained.
- Meets **diagnostic criteria** for gender incongruence prior to gender-affirming hormone treatment in regions where a diagnosis is necessary to access healthcare.
- Demonstrates **capacity to consent** for the specific gender-affirming hormone treatment.
- Other possible causes of apparent **gender incongruence** have been identified and excluded.
- Mental health and physical conditions that could negatively impact the outcome of treatment have been **assessed**, with risks and benefits discussed.
- Understands the effect of **gender-affirming hormone treatment** on reproduction and they have explored reproductive options.

****THESE WERE GRADED AS SUGGESTED CRITERIA.**

Initial Lab Work

Overview

INITIAL LAB WORK

Baseline

- CBC
- Lipid Profile
- Chemistry 18/CMP
- Hormone Levels
  - Testosterone level (Feminizing)
  - Prolactin level (Feminizing)
  - Estradiol (Masculinizing).
- HgA1C or Fasting Glucose

Feminizing Hormone Therapy

Feminizing Hormone Therapy
Overview

- **Main components:** Estrogen & Anti-Androgen.
- **Progesterone:** Controversial, not in CPGs.

Transgender females[a]	
Estrogen	
Oral	
Estradiol	2.0–6.0 mg/d
Transdermal	
Estradiol transdermal patch (New patch placed every 3–5 d)	0.025–0.2 mg/d
Parenteral	
Estradiol valerate or cypionate	5–30 mg IM every 2 wk 2–10 mg IM every week
Anti-androgens	
Spironolactone	100–300 mg/d
Cyproterone acetate[b]	25–50 mg/d
GnRH agonist	3.75 mg SQ (SC) monthly 11.25 mg SQ (SC) 3-monthly

Feminizing Effects

Effects in Transgender Females

Table 13. Feminizing Effects in Transgender Females

Effect	Onset	Maximum
Redistribution of body fat	3–6 mo	2–3 y
Decrease in muscle mass and strength	3–6 mo	1–2 y
Softening of skin/decreased oiliness	3–6 mo	Unknown
Decreased sexual desire	1–3 mo	3–6 mo
Decreased spontaneous erections	1–3 mo	3–6 mo
Male sexual dysfunction	Variable	Variable
Breast growth	3–6 mo	2–3 y
Decreased testicular volume	3–6 mo	2–3 y
Decreased sperm production	Unknown	>3 y
Decreased terminal hair growth	6–12 mo	>3 y[a]
Scalp hair	Variable	—[b]
Voice changes	None	—[c]

Monitoring of Feminizing Hormone Therapy

Gender-Affirming Hormone Therapy

Table 15. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Female

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of feminization and for development of adverse reactions.
2. Measure serum testosterone and estradiol every 3 mo.
   a. Serum testosterone levels should be <50 ng/dL.
   b. Serum estradiol should not exceed the peak physiologic range: 100–200 pg/mL.
3. For individuals on spironolactone, serum electrolytes, particularly potassium, should be monitored every 3 mo in the first year and annually thereafter.
4. Routine cancer screening is recommended, as in nontransgender individuals (all tissues present).
5. Consider BMD testing at baseline (160). In individuals at low risk, screening for osteoporosis should be conducted at age 60 years or in those who are not compliant with hormone therapy.

This table presents strong recommendations and does not include lower level recommendations.

Risks of Feminizing Hormone Therapy

Estrogen Overview

TRANSGENDER FEMALE: ESTROGEN

Very **high risk** of adverse outcomes:

- Thromboembolic disease

Moderate risk of adverse outcomes:

- Macroprolactinoma
- Breast cancer
- Coronary artery disease
- Cerevrovascular disease
- Chloelithiasis
- Hypertriglyceridemia

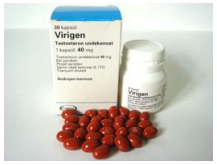
Masculinizing Hormone Therapy

Masculinizing Hormone Therapy

Overview

- **Main component:** Testosterone.
- For **refractory bleeding**: GnRH Agonist.

Transgender males	
Testosterone	
Parenteral testosterone	
Testosterone enanthate or cypionate	100–200 mg SQ (IM) every 2 wk or SQ (SC) 50% per week
Testosterone undecanoate[c]	1000 mg every 12 wk
Transdermal testosterone	
Testosterone gel 1.6%[d]	50–100 mg/d
Testosterone transdermal patch	2.5–7.5 mg/d



Masculinizing Additional Medications

Additional Medications

- **Testosterone** cream in Aquaphor for clitoral enlargement.
- **Estrogen** vaginal cream for atrophy.
- **Rogaine** or **Finasteride** for male pattern baldness.
- Use of **Progesterone**:
  - May help **reduce estrogen** levels and aid in cessation of menses before or after starting testosterone therapy.
- **GnRH Agonist** (Leuprolide):
  - May use to **cease menses**, if not stopped with testosterone alone.

Masculinizing Hormone Therapy

Effects

Table 12. Masculinizing Effects in Transgender Males

Effect	Onset	Maximum
Skin oiliness/acne	1–6 mo	1–2 y
Facial/body hair growth	6–12 mo	4–5 y
Scalp hair loss	6–12 mo	—[a]
Increased muscle mass/strength	6–12 mo	2–5 y
Fat redistribution	1–6 mo	2–5 y
Cessation of menses	1–6 mo	—[b]
Clitoral enlargement	1–6 mo	1–2 y
Vaginal atrophy	1–6 mo	1–2 y
Deepening of voice	6–12 mo	1–2 y

Masculinizing Hormone Therapy

Monitoring

Table 14. Monitoring of Transgender Persons on Gender-Affirming Hormone Therapy: Transgender Male

1. Evaluate patient every 3 mo in the first year and then one to two times per year to monitor for appropriate signs of virilization and for development of adverse reactions.
2. Measure serum testosterone every 3 mo until levels are in the normal physiologic male range:[a]
   a. For testosterone enanthate/cypionate injections, the testosterone level should be measured midway between injections. The target level is 400–700 ng/dL to 400 ng/dL. Alternatively, measure peak and trough levels to ensure levels remain in the normal male range.
   b. For parenteral testosterone undecanoate, testosterone should be measured just before the following injection. If the level is <400 ng/dL, adjust dosing interval.
   c. For transdermal testosterone, the testosterone level can be measured no sooner than after 1 wk of daily application (at least 2 h after application).
3. Measure hematocrit or hemoglobin at baseline and every 3 mo for the first year and then one to two times a year. Monitor weight, blood pressure, and lipids at regular intervals.
4. Screening for osteoporosis should be conducted in those who stop testosterone treatment, are not compliant with hormone therapy, or who develop risks for bone loss.
5. If cervical tissue is present, monitoring as recommended by the American College of Obstetricians and Gynecologists.
6. Ovariectomy can be considered after completion of hormone transition.
7. Conduct sub- and periareolar annual breast examinations if mastectomy performed. If mastectomy is not performed, then consider mammograms as recommended by the American Cancer Society.

[a]Adapted from Lapauw *et al.* (154) and Ott *et al.* (159).

Masculinizing Hormone Therapy

Risks

TRANSGENDER MALE: TESTOSTERONE

Very **high risk** of adverse outcomes:

- Erythrocytosis (hematocrit > 50%)

Moderate risk of adverse outcomes:

- Severe liver dysfunction (transaminases > threefold upper limit of normal)
- Coronary artery disease
- Cerebrovascular disease
- Hypertension
- Breast or uterine cancer

Surgical Gender Affirming Care

WPATH Criteria for Surgery

Adult Criteria

CRITERIA FOR HORMONES

- Gender incongruence is **marked** and **sustained.**
- Meets **diagnostic criteria** for gender incongruence prior to gender-affirming surgical intervention in regions where a diagnosis is necessary to access healthcare.
- Demonstrates **capacity to consent** for the specific gender-affirming surgical intervention.
- Understands the effect of **gender-affirming surgical intervention** on reproduction and they have explored reproductive options.
- Other possible causes of **apparent gender incongruence** have been identified and excluded.
- **Mental health** and **physical conditions** that could negatively impact the outcome of gender-affirming surgical intervention have been assessed, with risks and benefits discussed.
- Stable on their gender affirming **hormonal treatment regime** (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result, unless hormone therapy is either not desired or is medically contraindicated).

**These were graded as suggested criteria.

Feminizing Surgical Treatment

Referral

- For **Breast Augmentation**
  - 24 months of Gender Affirming Hormone Therapy.
  - Referral to Plastic Surgery at participating Military Treatment Facility (but may incur cost as not currently on medically necessary transition list).
- For **Surgery Impacting Fertility** (Orchiectomy) and genital reconstruction (Penectomy, Vaginoplasty)
  - Requires at least 12 months of Gender Affirming Hormone Therapy.
  - Requires at least 12 months of full-time Real-Life Experience (generally requires exception to policy (ETP)).
  - Requires 2 Mental Health evaluations.
  - Requires DHA Supplemental Healthcare Waiver for network care.
- **Cosmetic Procedures** (Chondroplasty, Facial Feminization)
  - May be performed at MTF with referral to Plastic Surgery.

Masculinizing Surgical Treatment

Referral

- **For Chest reconstruction**
  - 6 months Gender Affirming Hormone Therapy.
  - One MH evaluation.
  - Referral to Plastic Surgery at a Military Treatment facility.
- For **Surgery Impacting Fertility** (oophorectomy, hysterectomy, bilateral salpingectomy) and genital reconstruction (metoidoplasty, phalloplasty, scrotoplasty, testicular implants, penile proshetics)
  - Requires at least 12 months of Gender Affirming Hormone Therapy.
  - Requires at least 12 months of full-time Real-Life Experience (generally requires exception to policy (ETP)).
  - Requires 2 Mental Health evaluations.
  - Requires DHA Supplemental Healthcare Waiver for network care.

Transgender Healthcare in the Military

The Future

Administrative Changes

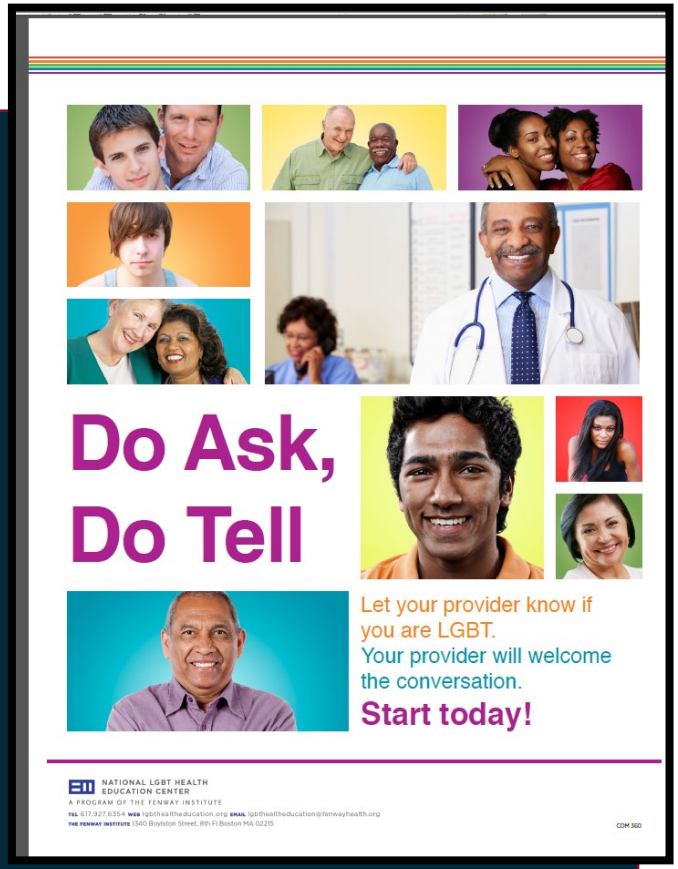
- Uniform documentation of counselling on **gender specific standards** (PRT, PFT, CFT).
- **Uniform documentation** of options for Exception to Policy, for routing

Consideration of Additional MTF Surgical Treatments

- Currently offering **chest reconstruction, hysterectomy** for transgender male service members, and orchiectomy, breast augmentation, cosmetic procedures for transgender female service members at select MTFs.

Communicating With Your Provider

"Do Ask, Do Tell"



Do Ask, Do Tell | Source : lgbtqiahealtheducation.org

Transgender Service Members

"We Are Already Here"

Department of Defense Instructions

Overview

- Department of Defense Directive-type Memorandum (DTM) 16-005, "**Military Service of Transgender Service Members**"
- Department of Defense Instruction (DoDI) 1322.22, Service Academies, September 24, 2015
- Department of Defense Instruction (DoDI) 1300.28, **In-Service Transition for Transgender Service Members**, April 30, 2021
- DoDI 6130.03 Incorporating Change 4, Effective November 16, 2022, **"Medical Standards for Military Service: Appointment, Enlistment, or Induction**"

Photo | Source: defense.gov

Instructions
Overview

- MILPERSMAN 1000-130, **Name Change of Member**
- MILPERSMAN 1000-131, **Member Gender Marker Change**
- Secretary of the Navy Instruction (SECNAV) 1000.11 **Service of Transgender Sailors and Marines**
- Secretary of the Navy Instruction (SECNAV) M-5510.30 **Secretary of the Navy Security regulations**
- OPNAV Instruction 3120.32E, "**Standard Organization and Regulations of the U.S. Navy**"
- OPNAV Instruction 5354.1 Series, **"Navy Equal Opportunity Policy"**
- OPNAV Instruction 5350.4D4E, **"Navy Alcohol and Drug Abuse Prevention and Control"**
- BUMED Note 6000, **Medical Treatment of Transgender Service Members – Interim Guidance**

Photo | Source: defense.gov

Additional Questions

- Clinical Questions
  - NMFL or NMFP Transgender Care Teams.
- Administrative Questions
  - Service Central Coordination Cells.
  - usn_navy_sccc@navy.mil

References

1. Center of Excellence for Transgender Health – www.tranhealth.ucsf.edu
2. Consumer Reports – Transgender Healthcare (Link)
3. Defense Technical Information Center – RAND Reporting Assessing the Implications of Allowing Transgender Personnel to Serve Openly (Link)
4. Endocrine Treatment of Gender-Dysphoric/Gender-Incongruent Persons – Clinical Practice Guidline (Link ; Link)
5. LGBT Resources Website – Online Training for All Personnel (Link)
6. My Navy HR – US Navy LGBT Resources (Link)
7. My Navy HR – Commander's Inclusion and Diversity Toolkit (Link)
8. National LGBT Health Education Center (Link)
9. Pubmed.gov – Welcoming Transgender and Nonbinary Patients: Expanding the Language of "Women's Health" (Link)
10. Transgender Unicorn – Transgender Student Educational Resources (Link)
11. World Professional Association for Transgender Health – Standards of Care (Link)

Questions & Answer Session

Conclusion : Day 2

THIS CONCLUDES DAY 2 OF THE VIRTUAL WOMEN'S HEALTH SEMINAR

- **REMINDER: You must register by 1300 ET on January 28th** to qualify for the receipt of CE/CME credit or certificate of attendance. *Please locate instructions for obtaining CE/CME credit in your email from 24 January.*
- Day 2 will begin tomorrow at 1000 ET with a presentation on Ongoing Efforts by the Office of Women's Health and the Female Force Readiness Navy Medicine Operational Clinical Community by LCDR Allison Eubanks.
- Please plan to log on by **09:45 ET** and ensure **your name is displayed** on Teams to ensure your attendance is captured.

Reminder: Obtaining Continuing Education Credits

You must register by 1300 ET on January 28th to qualify for the receipt of CE/CME credit or certificate of attendance. *Please complete the following steps to obtain CE/CME credit:*

- Go to https://www.dhaj7-cepo.com/
- If you have previously used the CEPO CMS, click login.
  - Search for your course (2023 Virtual Women's Health Seminar) using the Catalog, Calendar, or Find a course search tool.
  - Click on the REGISTER/TAKE COURSE tab.
  - PASSCODE (if required): WH2023
- If you have not previously used the CEPO CMS, click REGISTER to create a new account. Once you create your account follow steps 2a-c.
- Following the Seminar, you must complete the program posttest and evaluation before collecting your certificate. The posttest and evaluation will be available through **February 10th at 2359 ET**.
- Follow the onscreen prompts to complete the post-activity assessments:
  - Read the Accreditation Statement
  - Complete the Evaluation
  - Take the Posttest
- After completing the posttest at 80% or above, your certificate will be available for print or download.
- You can return to the site at any time in the future to print your certificate and transcripts at https://www.dhaj7-cepo.com/
- If you require further support, please contact dha.ncr.j7.mbx.cepo-cms-support@health.mil

THANK YOU FOR ATTENDING THE 2023 VIRTUAL WOMEN'S HEALTH SEMINAR!