

Take 3 – Practical Practice Pointers[®] March 11, 2019 Edition

Pelvic Examinations, Recurrent BV, Osteoporosis in Men

From the AAFP, Choosing Wisely, and Questions from Many

1) Pelvic Examination for Asymptomatic Women – Reprise

The AAFP in conjunction with the Choosing Wisely Campaign (CWC) released a recommendation regarding pelvic examinations in August of 2018. Specifically, the recommendation states, “Don’t perform pelvic exams on asymptomatic nonpregnant women, unless necessary for guideline-appropriate screening for cervical cancer.”

Rationale included the fact that screening pelvic examinations, except for the purpose of performing cervical cancer screening at recommended intervals, have not led to reduction in mortality or morbidity, and expose asymptomatic women to unnecessary invasive testing. Noninvasive options to screen for sexually-transmitted infections are now available as alternatives to endocervical cultures. Screening pelvic examinations also add unnecessary costs to the health care system, included expenses from evaluations of false-positive findings and even unnecessary surgery.

In July 2014, the American College of Physicians (ACP) released the following recommendation which was endorsed by the AAFP:

- ACP recommends against performing screening pelvic examination in asymptomatic, nonpregnant, adult women (strong recommendation).

This recommendation went on to clarify that the pelvic examination is defined as the speculum and bimanual examination. It indicated that performing routine pelvic examination adds both direct costs to the health care system and opportunity costs. There is low-quality evidence that screening pelvic examination leads to harms, including fear, anxiety, embarrassment, pain, and discomfort, and possibly prevents women from receiving medical care. In addition, false-positive screening results can lead to unnecessary laparoscopies or laparotomies.

In March of 2017, the USPSTF released the following statement for asymptomatic, non-pregnant adult women not at risk for any specific gynecological condition:

- The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of performing screening pelvic examinations in asymptomatic women for the early detection and treatment of a range of gynecologic conditions (I Recommendation). This statement does not apply to specific disorders for which the USPSTF already recommends screening (ie, screening for cervical cancer with a Pap smear, screening for gonorrhea and chlamydia).

In March of 2017, in response the USPSTF Statement, the American College of Obstetrics and Gynecology (ACOG) released the following Practice Advisory:

What the Task Force Recommendation Means:

- More research is needed, as indicated by the Task Force's "I" statement for insufficient evidence. Current recommendations are based on expert opinion.
- There are some women who may benefit from a screening pelvic examination depending on their individual health and information shared during the encounter.

What the Task Force Recommendation Does NOT Mean:

- The "I" statement from the Task Force should NOT be interpreted to mean that a screening pelvic examination should never be performed. This is NOT a recommendation that there is no net benefit or that the harms outweigh the benefits.
- It does NOT mean that women should forgo seeing an obstetrician-gynecologist at least once a year for well-woman care. This preventive service visit also provides an opportunity for the patient and her obstetrician-gynecologist to discuss whether a pelvic examination is appropriate for her (shared decision making).

My Comment:

This question has come up multiple times in the past 2 weeks, from colleagues, nurses, staff, and patients, so I concluded repetition from a previous Pointer was needed. The annual pelvic exam in the asymptomatic woman may be another medical "tradition" whose days appear to be numbered (like the "routine" digital rectal exam and others). I commend the AAFP and the ACP for their willingness to examine and report on the evidence and perhaps break the "conspiracy of silence" regarding this exam. It is heartening to see that ACOG is honest in stating that their guideline is based on expert opinion, though I would disagree with a statement in their 2016 "Committee Opinion" that the annual pelvic exam "seems logical." Like the digital rectal exam in men, it is an invasive examination that has extremely low sensitivity and specificity. Perhaps these recommendations will give them impetus to perform the research they say is needed?

In my own practice, I discuss the recommendations with my patients and we together decide. Not surprisingly, most are quite happy to skip it. For those who continue to do this exam "routinely", I would challenge you with this question: Since part of the exam is to palpate the ovaries, if you are unable to feel the ovaries (body habitus being the most common reason after examiner skill), do you proceed to a pelvic ultrasound due to the inadequacy of your "screening exam"?

References:

- Choosing Wisely Campaign August, 2018: [Link](#)
- Screening Pelvic Examination in Adult Women: A Clinical Practice Guideline From the ACP. *Ann Intern Med.* 2014;161(1):67-72. 1 July, 2014. [Link](#)
- ACOG Practice Advisory – Screening Pelvic Examination: March 2017: [Link](#)
- USPSTF Recommendation Statement: Gynecological Conditions: Periodic Screening With the Pelvic Examination. March 2017. [Link](#)

Question From a Colleague

2) Treatment for Recurrent Bacterial Vaginosis (BV)

Question: I recently saw a patient for symptoms of recurrent bacterial vaginosis. She had no other risk factors/complaints that would require a pelvic/speculum exam or STD testing. My practice has been to just do a deep vaginal swab for wet prep without a speculum. My questions are, is this an acceptable approach and what is the latest guidance regarding the treatment of recurrent BV?

Answer: Bacterial vaginosis (BV) is the most common cause of abnormal vaginal discharge in reproductive-age women. Treatment is aimed at relieving symptoms, although many women are asymptomatic. Of those women with symptoms, abnormal

vaginal discharge and fishy odor are typical. Treatment is indicated for relief of symptoms in women with symptomatic infection. BV resolves spontaneously in up to one-third of nonpregnant and one-half of pregnant women.

It is estimated that 30 percent of women with initial responses to therapy have a recurrence of symptoms within three months and more than 50 percent experience a recurrence within 12 months. The reason for this is unclear. Though reinfection is possible, recurrence more likely reflects a failure to eradicate the offending organisms or to reestablish the normal protective vaginal flora dominated by lactobacillus. Infections involving biofilms can be more difficult to eradicate.

Treatment recommendations for recurrent or resistant infections are based on limited data. A seven day course of oral or vaginal metronidazole or clindamycin is a reasonable first step. Alternately, vaginal boric acid suppositories 600 mg once daily for 30 days can be used as an induction regimen or to follow seven-day oral treatment. Most women with a history of documented recurrent infection (> 3 episodes over 12 months) will benefit from suppressive therapy to maintain an asymptomatic state. The recommended regimen is 0.75% metronidazole vaginal gel twice weekly for 4-6 months. Secondary vaginal candidiasis was a common side effect, so providing a prescription for fluconazole is reasonable. Clindamycin 2% gel is less effective.

Less well studied treatment options could include use of condoms or sexual abstinence and treatment with lactobacillus probiotics (very little evidence for efficacy). Ineffective treatments include use of vaginal acidifying agents alone, douching, probiotics alone. Data do not support treatment of asymptomatic male or female sexual partners.

My Comment:

While there is some data regarding patient collected vaginal swabs which indicates that the diagnosis is incorrectly missed in approximately 1/3 of the time, I could find no data regarding a physician obtained deep vaginal swab. UpToDate states “omission of the speculum examination results in under-diagnosis and should be avoided,” but provides no reference. So I would say that a speculum exam would still be considered “standard of care,” but that would be based at best on “expert opinion” and more likely on “tradition” (refer to Pointer 1).

Reference:

CDC – Bacterial Vaginosis: [Link](#)

From the Literature

3) Diagnosis and Treatment of Osteoporosis in Men

Osteoporosis is common with prevalence of 20%-40% in postmenopausal women and 6%-8% men ≥ 50 years old. Older veterans, especially men, often have a high risk for hip fracture along with low rates of recommended further testing and preventive therapy, a large study has found. A 2010 VA inspector general report showed that 25% of male veterans who had a hip fracture died within a year.

The diagnosis is made for those with fragility fracture, regardless of any test results. The National Osteoporosis Foundation recommends using DEXA measurement at posterior-anterior spine and hip include the following:

- all women ≥ 65 years old, and all men ≥ 70 years old
- postmenopausal women < 65 years old, perimenopausal women, and men aged 50-69 years with clinical risk factors for fracture (or use a risk calculator to predict 10-year risk of fracture)
- any adult with fracture after age 50 years
- any adult with condition (such as rheumatoid arthritis) or use of medication (such as glucocorticoids for ≥ 3 months) associated with low bone mass or bone loss

The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits/harms of screening for osteoporosis to prevent osteoporotic fractures in men.

This recent study from the VA compared osteoporosis case-finding, evaluation and treatment in groups of older men and women with age alone as a significant risk for fracture and older men with higher risk (previous hip fracture, corticosteroid use or androgen deprivation therapy). One main outcome measure was the proportion of patients who had DEXA bone mineral density measurement performed, and bisphosphonates prescribed.

The proportion of men with a 10-year hip fracture risk $\geq 3\%$ (threshold for starting preventive therapy) with age alone as a risk was 48% in men aged 75–79 and 88% in men ≥ 80 years. Compared with older women, fewer men underwent DEXA (63% vs. 12%) and fewer received bisphosphonate prescriptions (44% vs. 5%). In the older men group with higher risk, the proportion of men with 10-year hip fracture risk $\geq 3\%$ ranged from 69% to 95% (stratified by risk category). Despite a higher risk and expectation that this group would have greater case detection and screening, only about 1/3 of older men with higher risk underwent DEXA screening and of those eligible only about 1/5 received bisphosphonate prescriptions.

Acknowledging the limitation that this was a retrospective study in a population of veterans, the authors concluded that their findings underscore the need for improved evaluation and management of osteoporosis in older men at risk for fracture.

My Comment:

My observation is that screening for men is still not considered in clinical practice for many clinicians, regardless of risk factors. Hopefully this Pointer will at least keep it on our clinical “radar screen.”

Reference:

Narla R, et al. Suboptimal osteoporosis evaluation/treatment in older men with and without additional high-risk factors for fractures. J Investig Med. Online February 5, 2019. [Abstract](#)

USPSTF Screening for Osteoporosis to Prevent Fractures – July 2018: [Link](#)
National Osteoporosis Foundation. Clinician's Guide to Prevention and Treatment of Osteoporosis. Washington, DC: National Osteoporosis Foundation; 2014. [Link](#)

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