1. Although the ACOG recommendation is to initiate gynecologic care at age 13-15 years, many patients are still exclusively seeing a pediatrician at this stage. Additionally, due to a variety of reasons, pediatricians are also counseling patients and administering the HPV vaccine. What suggestions do you have for facilitating coordination of care between gynecology and pediatrics?

Response from Dr. Joseph Sanfilippo and Dr. Eduardo Lara-Torre:

Primary care healthcare providers are commonly uncomfortable discussing issues related to reproductive health such as pregnancy prevention, sexuality, contraception, sexually transmitted infection, and menstrual hygiene and management. Time constraints and overflow of patients make it difficult to address all of these issues during their regular preventive visits.
Physician-to-physician communication is important to educate our primary care colleagues to focus on the reproductive aspects of this age group to improve the provision of care and prevent patients from not receiving counseling and services. A close collaboration between specialties can be fostered by establishing a direct easy access line for patient referrals, as well as returning the patients to their pediatrician for all other aspects of non-reproductive preventive care. These interactions will foster the best care for teens, while maintaining the pediatricians’ lead in the overall health of the adolescent.

2. Although it is possible to maintain patient confidentiality with regards to sexual history and examination, many patients are reluctant to undergo STD testing or fill prescriptions for contraceptives because charges appear on their parents’ insurance bill. What alternatives are available to adolescents in these situations?

Response from Dr. Joseph Sanfilippo and Dr. Eduardo Lara-Torre:

There are a few alternatives. Some practices, especially academic resident clinics, have developed low-cost or free family planning clinics that provide these services to teens and protect their privacy.

Utilizing pharmaceutical company samples for these patients is one way the problem has been addressed, but the availability of the samples is limited, and high-volume practices may not allow this strategy to be feasible.

Utilizing contacts with the free state-sponsored Health Department clinics and Planned Parenthood may provide these patients with the best option. These sites provide free services that include contraception and STI testing at no charge to most teens and have accessible sites and hours that allow patients to attend even during school days. Some centers have developed agreements with the Health Departments and send their STI screen tests to their lab for processing at no charge to the patients, allowing providers from private offices to continue to care for them.
3. What is the potential benefit of HPV immunization in adolescents already diagnosed with HPV or cervical dysplasia?

Response from Dr. Joseph Sanfilippo and Dr. Eduardo Lara-Torre:

The current recommendations from the manufacturer and the American College of Obstetricians and Gynecologists regarding vaccination of patients with previous HPV disease state that patients should be aware of the possible decrease in efficacy of the vaccine if the HPV disease was caused by one of the serotypes in the vaccine. Patients should also be encouraged to receive the vaccine as the benefit from the protection for the 4 serotypes it contains will remain, and their disease may not have been caused by one of these viruses. Patients should continue routine cervical cancer screening and be educated on the preventive and not therapeutic nature of the vaccine.

4. In what situations would the bivalent HPV vaccine be preferred to the quadrivalent vaccine?

Response from Dr. Joseph Sanfilippo and Dr. Eduardo Lara-Torre:

Currently the bivalent vaccine is not approved for marketing in the United States, and research is underway to address the efficacy of bivalent compared with quadrivalent HPV vaccines.
5. What is the role, if any, for an intravenous estrogen regimen for acute, life-threatening menorrhagia in adolescents?

Response from Dr. Joseph Sanfilippo and Dr. Eduardo Lara-Torre:

There is currently no evidence to suggest that using estrogen alone in adolescents is better than any other treatment for menorrhagia, such as combined oral contraceptives, progestin-only contraceptive pills, or medroxyprogesterone. Even in adults, the literature is scant and limited to a single paper published in the 1980s, and the treatment was not compared to other modalities. The use of estrogen in teens should be reserved for patients with uncontrollable dysfunctional uterine bleeding. Such therapy should be accompanied by antiemetics and followed by prescription of oral contraceptives in the traditional manner.

6. What are the major factors that contribute to the lower rate of adolescent pregnancy in Europe and Canada compared with the United States?

Response from Dr. Joseph Sanfilippo and Dr. Eduardo Lara-Torre:

The major factors are comprehensive reproductive health education, access to contraception, and societies’ beliefs.

Patients in Europe and Canada have better access to contraceptive care than most U.S. women. Also, the education provided to the public and in school has a comprehensive approach rather than abstinence only, which allows for better understanding of their options. The difference in education on sexuality as a whole in specific cultures also plays a role. It removes the taboo from discussing sexuality, making it a natural part of life. This attitude contributes to a better understanding of the topic and a better approach to responsible sex and, hence, lower overall pregnancy rates.
7. Should bone density be monitored in adolescents on long-term (more than 2 years) DMPA therapy, and if so, how often? How quickly is bone mass recovered after discontinuation? Are there any additional therapies available to adolescents unwilling to discontinue DMPA despite bone loss?

Response from Dr. Joseph Sanfilippo and Dr. Eduardo Lara-Torre:

There is no standard recommendation for the follow-up of patients who require DMPA for longer than 2 years. It is up to the practitioner to use densitometry to follow up these patients, but no consensus exists. If the choice is made to follow-up, every other year bone mineral density scans using “Z” scores should be used to be able to compare cohorts of the same age rather than the standard “T” score used in adults. Literature suggests that the bone loss seen on DMPA use is regained within the year after discontinuation and patients’ bone mass is equal to non-users. For those patients using long-term DMPA, calcium supplementation, weight-bearing exercise, and smoking cessation should be encouraged as general preventive interventions. The use of low-dose estrogen supplementation (such as conjugated estrogen 0.625 mg orally daily) may be used as “add-back” therapy in these patients, but long-term studies using this therapy are not available.

8. Are there any differences in the method of screening an adolescent for abuse, compared with screening an adult?

Response from Dr. Joseph Sanfilippo and Dr. Eduardo Lara-Torre:

In large part, it is all in the language used. Adolescents are concrete thinkers. Questions need to be asked directly and clearly. They are unlikely to voluntarily disclose information. Sometimes abuse must be described clearly so they understand what you are asking. The screening needs to occur in private (guarantee of privacy), and the teen needs to be assured of the confidential nature of the information. Having sex in some instances may have seemed
voluntary but was forced on them. Remember that a large proportion of college students have had an abusive relationship by the end of college, many times seen as consensual by the perpetrator. Reassurance and age-appropriate resources should be available during these discussions, as well as the requirement to report to the authorities in cases where minors are involved, even if the patient does not desire to report (seek local law guidance).