

Your age-based guide to comprehensive well-woman care

➔ Primary care interventions vary with the age of the patient, but there are similarities, too. A look at recommendations for four age intervals: 13–18, 19–39, 40–64, and over 65.

Robert L. Barbieri, MD Editor in Chief

The American College of Obstetricians and Gynecologists (ACOG) has recommended dividing a woman's life cycle into four intervals—ages 13–18, 19–39, 40–64, and older than 65—in order to best organize the approach to primary and preventive health care.¹ This paradigm provides a structure for organizing the clinical approach to physical examination, laboratory testing, counseling, and immunizations. In addition, it helps to highlight the diseases and health problems most prevalent among women at each life-stage.

Different professional organizations—US Preventive Services Task Force (USPSTF), American Medical Association, American College of Physicians, ACOG, American Academy of Family Physicians, American Academy of Pediatrics, and Advisory Committee on Immunization Practices—have used varying analytical methods to determine recommended health services by age group; consequently, these organizations

have somewhat divergent recommendations. However, the recommendations of most organizations share many similarities. In this comprehensive guide, I point out those similarities. Keep in mind that recommendations change over time, and it is important to use your professional judgment when approaching each patient.

The adolescent: 13–18 years Screen. Guide. Immunize.

ACOG recommends that the first visit take place between 13 and 15 years of age, with annual visits thereafter. The purpose of the first, and subsequent, visits is to assess health status, including menstrual history and body mass index (BMI), and to provide health guidance, screening, and preventive health services. This initial visit generally does not include a pelvic examination. A physical examination is not required at every visit but is recommended to occur at least once during early, middle, and late adolescence.

Target your screening practices. Screen adolescents for the following conditions during clinical preventive services: hypertension; hyperlipidemia; obesity and eating disorders; physical, sexual, or emotional abuse; learning or school problems; substance use; depression and risk of suicide; sexual assault; sexual behavior that may lead

IN THIS ARTICLE

Physical exam and lab testing services according to age

page 24

Preventive care coding

page 26

Issues of concern no matter a woman's age

page 28

Age-based causes of death

page 30



Dr. Barbieri is Chief, Department of Obstetrics and Gynecology, Brigham and Women's Hospital, and Kate Macy Ladd Professor of Obstetrics, Gynecology, and Reproductive Biology, Harvard Medical School, Boston, Massachusetts

Dr. Barbieri reports no financial relationships relevant to this article.

to pregnancy or sexually transmitted disease (STD); and tuberculosis and HIV, unless the patient opts out (TABLE, page 24).

Anticipate. Then guide. Using anticipatory guidance, you can help adolescents understand their physical, psychosocial, and sexual development and motivate them to be involved in their health and health-care decisions. Issues relevant to adolescents include dietary habits; injury prevention, through the use of helmets and seatbelts; regular exercise; responsible sexual behaviors; avoidance of substances that can be abused; strategies for dealing with bullying; and avoidance of behaviors that might have negative consequences, such as vandalism, stealing, and sharing personal information with strangers.

Recommended immunizations. For this age group, immunizations, unless previously given, include:

- 1 or 2 doses of measles, mumps, and rubella
- 2 doses of varicella if not previously infected
- a booster dose of tetanus if ≥ 10 years have elapsed since the last dose
- human papillomavirus (HPV)
- annual influenza.

Other immunizations that may be warranted on the basis of medical condition, occupation, lifestyle, or other indications include: 3 doses of hepatitis B, 2 doses of hepatitis A, 1 or more doses of meningococcal, and 1 or 2 doses of pneumococcal.

Menses, an important “vital sign.” Once menstruation begins, evaluating menstrual cycle characteristics is important. Patterns that may require evaluation include²:

- no menses within 3 years of thelarche
- no menses by age 13 with no sign of pubertal development
- no menses by age 14 with signs of hirsutism
- no menses by age 14 with indications of an eating disorder
- no menses by age 15
- history of regular menses that are now markedly irregular
- menses occur more frequently than 21 days or less frequently than every 45 days
- menses occur 90 days apart for one cycle
- menstrual bleeding that lasts more than 7 days

- frequent tampon/pad changes (more than 1 tampon/pad every 1 to 2 hours).

BMI predicts future disease. Overweight and obesity are important risk factors for diabetes mellitus, hyperlipidemia, hypertension, and various cancers. Eating disorders are common among adolescents and often occur in association with other mental health problems.

Non-sexually active teens and children

Gynecologic examination typically involves inspection of the genitalia and not instrumentation of the vagina. A careful explanation of the proposed examination is important. Ask young adolescents who they would like to have in the examination room with them. A hand mirror can be used to involve the patient in the genitalia inspection. If it's necessary to obtain magnification, use a hand lens, an otoscope without the speculum, or a colposcope. Record the configuration of the hymen, if present. If indicated, examination of the genitalia while the patient is in the knee-chest position often provides a good view of the vagina and sometimes the cervix, without instrumentation.

Sexually active teens

Effective contraception, including the use of emergency contraceptives, is an important health focus for sexually active teens. Vaginal speculum examination and bimanual gyn exam are not required prior to prescribing hormonal contraceptives to teens. Based on a review of the evidence and expert opinion,³ the current recommendation is that **prior to prescribing a hormonal contraceptive, a medical history and blood pressure measurement are the only requirements**; breast examination and a gyn exam (vaginal speculum and bimanual gyn exam) are not necessary. Testing for chlamydia and gonorrhea can be performed using a urine sample. A cervical cytology examination is not necessary until age 21 unless the patient is in a high-risk group, such as immunosuppressed or HIV-infected teens.



Understand the health issues that affect adolescents and motivate them to be active decision makers in their health care

CONTINUED ON PAGE 22

The young woman: 19–39 years

Focus on reproductive issues. Contraception, pregnancy, and cervical cancer screening are common reasons for visits among women in this age group. Gynecologic problems can include polycystic ovary syndrome (PCOS), endometriosis, fibroids, infertility, pelvic pain, vulvovaginal pain syndromes, vaginitis, adnexal masses, and STDs, including pelvic inflammatory diseases.

Offer effective contraception

Long-acting reversible contraceptives (LARCs) are the most clinically and cost-effective forms of reversible contraception. There are three LARC methods available in the United States: **1)** the copper T380A intrauterine device (IUD; Paragard), **2)** the levonorgestrel-releasing intrauterine system (Mirena), and **3)** the single-rod etonogestrel implant (Implanon, Explanon).

The use of IUDs among American women has increased from about 2.4% of contraceptive women of reproductive age in 2002 to 8.5% in 2009.⁴ In Norway and France, contraceptive women of reproductive age use IUDs at a rate of 27% and 23%, respectively.⁵ Typical-use pregnancy rates for LARCs are lower and continuation rates are higher than observed with oral contraceptives (OCs).

In an economic analysis, the cost of LARCs was lower than almost all other forms of reversible contraception over a 5-year interval.⁶ When financial and access barriers are removed, **most women starting a contraceptive will use a LARC, if offered.**⁷

Be aware of STDs

STDs are common in this age group. In the United States, chlamydial genital infections reach a peak in women 18 to 25 years old, with a prevalence of about 4%.⁸

Counsel her about exercise and weight loss

Approximately 60% of women older than age 20 are overweight or obese.⁹ The rise in obesity is a key contributing factor to an increase in many diseases, including gestational diabetes, type 2 diabetes mellitus, and

hypertension. Successful efforts to reduce the prevalence of obesity through diet and exercise could markedly improve population health.

Don't overlook autoimmune conditions

Many autoimmune diseases reach a peak incidence between ages 19 and 39, and, except for ankylosing spondylitis, are more of a concern for women than men. Systemic lupus erythematosus, lymphocytic thyroiditis, and rheumatoid arthritis occur much more frequently in women than in men, with ratios in the range of 7:1 observed during this age interval.

Keep her immunity up to date

Immunizations recommended in this age group include:

- one Tdap (tetanus toxoid, diphtheria, and pertussis)
- tetanus every 10 years
- influenza annually
- varicella if no evidence of immunity
- HPV for those aged 26 years or younger.

The mature woman: 40–64 years

Transition to postmenopause. The menstrual changes through perimenopause to postmenopause are often accompanied by changes in sleep patterns, vasomotor symptoms, and increasing vaginal dryness.

Open your eyes to a patient's insomnia

Perimenopausal and postmenopausal women report a much higher rate of insomnia than age-matched men.¹⁰ Women with moderate to severe vasomotor symptoms are more likely to report greater nighttime wakefulness and a greater number of nighttime long-awake episodes than women with mild vasomotor symptoms.¹¹ Insomnia can be associated with poor work performance and mood changes.

Hormone therapy: Be conservative

In the past, hormone therapy, with various estrogen and progestin combinations, was recommended to help prevent a number of



Important health concerns for women aged 19–39 include contraception, STDs, and weight-related and autoimmune conditions

TABLE Physical examination and laboratory testing services according to a patient's age, based on ACOG recommendations¹

Health service	13–18 years	19–39 years	40–64 years	65 years and older
Physical examination				
Height	X	X	X	X
Weight	X	X	X	X
BMI	X	X	X	X
Blood pressure	X	X	X	X
Tanner staging of secondary sexual characteristics	X			
Neck exam (assess thyroid and presence of adenopathy)		X	X	X
Breast exam		X	X (including axillae)	X (including axillae)
Oral cavity			X	X
Abdominal exam	X	X	X	X
Pelvic exam	If indicated	Age 21 and older	X	X
Skin exam		X	X	X
Laboratory testing				
Chlamydia	If sexually active	If age 25 or younger and sexually active		
Gonorrhea	If sexually active	If age 25 or younger and sexually active		
HIV	If sexually active	X	X	
Cervical cytology		Age 21-29: Every 2 years Age 30 and older, low risk: Every 3 years Age 30 and older, high risk (immunosuppressed or HIV infection): Annually	Low risk: Every 3 years High risk (immunosuppressed or HIV infection): Annually	Consider discontinuing in women with: -3 or more normal results in a row -no abnormal results in 10 years -no history of cervical cancer
Colorectal cancer screening (colonoscopy preferred)			Age 50 and older, low risk: Every 10 years High risk: Consult colorectal screening guidelines*	Every 10 years
Fasting glucose			Age 45 and older: Every 5 years	Every 5 years
Lipid profile			Age 45 and older: Every 5 years	Every 5 years
Mammography			Age 40 to 49: Every 1-2 years Age 50 and older: Annually	Annually
BMD				Not more frequently than every 2 years
TSH				Every 5 years
Urinalysis				X

Abbreviations: BMD, bone mineral density; BMI, body mass index; HIV, human immunodeficiency virus; TSH, thyroid stimulating hormone.

¹Levin B, Lieberman DA, McFarland B, et al. Screening and surveillance for the early detection of colorectal cancer and adenomatous polyps, 2008: a joint guideline from the American Cancer Society, the US Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology. *CA Cancer J Clin.* 2008;58(3):130–160.

Preventive coding can be a snap

Melanie Witt, RN, CPC, COBGC, MA

Coding and billing for the care provided at a well-woman visit can be uncomplicated if you know the right codes for the right program. Here, I present information for straightforward preventive care. (I am assuming the patient has not also presented with a significant problem at the same visit.)

First, a patient who is not Medicare-eligible should have the annual well-woman exam billed using the CPT preventive medicine codes. There are some private insurers, however, that will only accept HCPCS codes for an annual gyn exam. These special codes are:

S0610 Annual gynecological examination, new patient

S0612 Annual gynecological examination, established patient

S0613 Annual gynecological examination; clinical breast examination without pelvic evaluation

Notably, Aetna Cigna, and United Healthcare require these codes for a gyn exam, but many BC/BS programs, for whom these codes were originally created, are now reverting to the CPT preventive medicine codes for all preventive care.

The CPT preventive codes are grouped by age and require an age- and gender-appropriate history, examination, and counseling/anticipatory guidance. The Medicare E/M documentation guidelines do not apply to preventive services, and a head-to-toe examination is also not required. CPT recognizes ACOG as an authoritative body to make recommendations for the expected preventive service for women, and if such a service is provided and documented, the preventive codes are to be reported.

The chart below summarizes the CPT preventive codes by patient status and age in comparison to ACOG age groupings.

New Patient Preventive Medicine Code

New patient codes include an *initial comprehensive* preventive medicine evaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures

ACOG: 13–18 years	ACOG: 19–39 years	ACOG: 40–64 years	ACOG: 65 years and older
99384 (12–17 years)	99385 (18–39 years)	99386 (40–64 years)	99387 (65 years and older)
99385 (18–39 years)			

Established Patient Preventive Medicine Codes

Established patient codes include *periodic comprehensive* preventive medicine reevaluation and management of an individual including an age- and gender-appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures

ACOG: 13–18 years	ACOG: 19–39 years	ACOG: 40–64 years	ACOG: 65 years and older
99394 (12–17 years)	99395 (18–39 years)	99396 (40–64 years)	99397 (65 years and older)
99395 (18–39 years)			

The main code

The appropriate diagnostic link for the CPT preventive gyn annual well-woman exam is **V72.31**, whether or not a Pap specimen is collected. The collection of the Pap specimen is included in the preventive service, as is counseling regarding birth control, or general questions about preventing problems, including hormone replacement therapy.

diseases, including cardiovascular disease (CD) and osteoporosis. Based on clinical trial results, the current recommendation is to limit the use of hormone therapy in postmenopausal women to the treatment of vasomotor symptoms and vaginal symptoms caused by hypoestrogenism. To treat these problems, the lowest doses of hormones that are effective should be used for the

shortest periods of time that achieve symptom resolution.

The older woman: 65+ years

Successful aging. Based on observational studies, behavioral and health factors associated with successful aging include more than 12 years of education; high socioeconomic

If a pelvic examination is not performed, say because the patient is young and not sexually active, but an examination of other areas is carried out, the same preventive codes are reported, but the diagnosis code changes to **V70.0**, *general health exam*.

What about Medicare?

Coding. Medicare requirements are somewhat different. First, Medicare covers only a small portion of the preventive service; that is, they cover a physical examination of the genital organs and breasts and the collection and conveyance of a Pap specimen to the lab in the covered year only. Think of the complete preventive service as described in CPT as a pie—Medicare pays for 2 slices of that pie in a covered year. The two codes for these services are:

G0101 (*Cervical or vaginal cancer screening; pelvic and clinical breast examination*)

Q0091 (*Screening Papanicolaou smear; obtaining, preparing, and conveyance of cervical or vaginal smear to laboratory*)

If the patient is at **low risk** for developing cervical or vaginal cancer, the screening pelvic exam and Pap collection are paid every 2 years. If the woman is at **high risk**, Medicare will cover this portion of the encounter every year. The high-risk criteria must be re-documented every year and must include one of the following:

1. Early onset of sexual activity (under age 16)
2. Multiple sexual partners (five or more in a lifetime)
3. History of a sexually transmitted disease (including HIV infection)
4. Fewer than three negative Pap smears within the previous 7 years
5. Diethylstilbestrol (DES)-exposed daughters of women who took DES during pregnancy.

If the Medicare-eligible patient is still of childbearing age, she is also considered high-risk if she has had an examination that indicated the presence of cervical or vaginal cancer or other genital abnormalities during any of the preceding 3 years. Note that these criteria do not include a history of breast cancer or a past history of cancer more than 3 years ago.

Billing. Because Medicare is paying only for a portion of the preventive service, you will need to subtract the Medicare allowable for codes G0101 and Q0091 from your normal fee for the preventive service.

Example: If your usual fee for 99397 is \$200, and the Medicare allowable for both the G and Q service is \$82, you will charge the patient for the noncovered parts of the service at the rate of \$118, and you will bill Medicare for their share of \$82. You will collect from all sources the \$200 for the preventive service. Remember, however, to get the patient to sign an ABN with regard to the Medicare part of the service. This will ensure that, if denied by Medicare, the patient will be held fully responsible for the denied amount.

The Medicare modifier is **-GA** (add it to codes G0101 and Q0091). Diagnostic coding is **V72.31** (because a pelvic exam is performed). This code may also be linked to the collection code. For a high-risk patient, use code **V15.89** (rather than V72.31). This code must be linked to the G and Q codes.

Go to obgmanagement.com for a detailed Medicare checklist. This special handout, offered by the author, includes all billing scenarios for a Medicare patient. Ms. Witt can be contacted directly at nielynco@aol.com should you have additional questions regarding coding and billing for preventive services.

Ms. Witt is an independent coding and documentation consultant and former program manager, department of coding and nomenclature, American Congress of Obstetricians and Gynecologists.

status; absence of diabetes, asthma, stroke, and lower respiratory tract disease; absence of depression; presence of at least five close personal contacts; frequent walking; moderate use of alcohol; and nonsmoking status.¹²

Know her risks, and watch for them Cardiovascular disease. Among women, CDs cause more deaths than malignant

neoplasms, chronic lower respiratory disease, Alzheimer's disease, and accidents combined. Black women have rates of CD approximately 40% greater than white women. Hypertension, hypertriglyceridemia, obesity, and sedentary lifestyle among black women account for a part of this increased risk.

Effective lifestyle interventions for primary CD prevention in women include

ON THE WEB

A special downloadable handout including all Medicare billing scenarios, at obgmanagement.com

smoking cessation, a diet such as DASH (Dietary Approaches to Stop Hypertension) rich in fruits and vegetables, regular physical activity, and weight management.¹³

There are important gender differences in aspirin efficacy for primary prevention of stroke and myocardial infarction (MI) in men and women. Among women, aspirin used for primary prevention appears to reduce the risk of stroke but not MI.¹⁴ Among men, aspirin used for primary prevention appears to reduce the risk of MI but not stroke.^{15,16} Based on these and other data, the USPSTF has recommended that aspirin not be used to prevent stroke in men but recommends aspirin to prevent stroke among women 55 to 79 years of age when benefits outweigh risks of gastrointestinal bleeding.¹⁷

Atrial fibrillation (AF), a risk factor for stroke, is more common in women than in men. In addition, women with AF who are not anticoagulated are at greater risk for stroke than men with AF who are not anticoagulated.¹⁸ The mechanisms that influence these gender differences are not well characterized. **Respiratory illness.** Among women, the prevalence of chronic bronchitis and emphysema increased more than 2.8-fold from 1980 to 2000.¹⁹ These diseases are major contributors to physician office visits, hospitalizations, disability, and death. Tobacco use is the major risk factor that accounts for the marked increase in COPD among women during recent decades, although ambient pollutants in the environment, home, and workplace are also important contributors to COPD development.

Cognitive decline. Alzheimer's disease afflicts approximately twice as many women as men. Part of this difference is due to the greater longevity of women, but additional variables, such as gender differences in neurobiology, are also contributory. The role of estradiol in the development of Alzheimer's disease remains controversial.

Osteoporosis. This disease occurs about five times more frequently in women than in men. Among Medicare patients, the cost of caring for a hip fracture is more than \$40,000 in the first year postfracture. Hip fracture is

associated with a high risk of rapid health decline. Interventions that successfully prevent hip fracture are associated with a reduced mortality rate.^{20,21}

A concern at any age

Domestic violence

Domestic violence is common; approximately 5% of women report one episode during the past year and 25% report at least one lifetime episode.²² Domestic violence involves two people: a perpetrator and a victim. In some relationships, a recurrent cycle of violence and reconciliation is observed. Routine, confidential, and private screening is required to detect most cases of domestic violence.

Ask the right question(s). The single question, "At any time, has a partner hit, kicked, or otherwise hurt or threatened you?" can increase the rate of detection. Alternatively, a set of three questions can be used to screen for domestic violence:

1. "Within the past year, have you been hit, slapped, kicked or otherwise physically hurt by someone?"
2. "Within the past year, has anyone forced you to have sexual activity?"
3. In pregnancy: "Since you have been pregnant, have you been hit, slapped, kicked, or otherwise physically hurt by someone?"

Follow-up and refer. If a woman reports that she has suffered or is at risk for domestic violence, document the finding in her medical record. Then try to assess her safety by asking: "Are there guns in the home?", "Have there been threats of suicide or homicide?", "Has there been violence toward children?" Choking, specifically, could be a sign of future escalated violence—as many perpetrators choke their victims prior to further, escalated violence occurring—and should be taken as a threat of homicide. Refer women who report domestic violence to a specialist; often, the best trained and most available experts are experienced social workers.

Sexual assault

About 25% of women report at least one lifetime sexual assault. Most women who



When treating the older woman, strive to keep her heart, mind, and bones healthy

What may lead to your patient’s death, according to her age?

Keep in mind the top causes of death for her age when you examine and counsel your patient. For a young teenager, for instance, accidents are the most common cause of death. Therefore, emphasize to her the importance of risk-reducing interventions, such as wearing helmets while biking and seatbelts while driving and practicing water sports safely.

Age 13–18 years	Age 19–39 years
1. Accidents (unintentional injuries)	1. Malignant neoplasms
2. Malignant neoplasms	2. Accidents (unintentional injuries)
3. Intentional self-harm (suicide)	3. Diseases of the heart
4. Assault (homicide)	4. Intentional self-harm (suicide)
5. Diseases of the heart	5. Human immunodeficiency virus disease
6. Congenital malformations, deformations, and chromosomal abnormalities	6. Assault (homicide)
7. Chronic lower respiratory diseases	7. Cerebrovascular diseases
8. Cerebrovascular diseases	8. Diabetes mellitus
9. Influenza and pneumonia	9. Chronic liver diseases and cirrhosis
10. In situ neoplasms, benign neoplasms, and neoplasms of uncertain or unknown behavior	10. Chronic lower respiratory diseases
Age 40–64 years	Age 65 years and older
1. Malignant neoplasms	1. Diseases of the heart
2. Diseases of the heart	2. Malignant neoplasms
3. Accidents (unintentional injuries)	3. Cerebrovascular diseases
4. Chronic lower respiratory diseases	4. Chronic lower respiratory diseases
5. Cerebrovascular diseases	5. Alzheimer’s disease
6. Diabetes mellitus	6. Influenza and pneumonia
7. Chronic liver disease and cirrhosis	7. Diabetes mellitus
8. Septicemia	8. Nephritis, nephritic syndrome, and nephrosis
9. Intentional self-harm (suicide)	9. Accidents (unintentional injuries)
10. Human immunodeficiency virus disease	10. Septicemia

Source: Mortality Statistics Branch, National Center for Health Statistics; 2004.

report being raped initially receive care in a hospital-based emergency department from nurses who are credentialed in Sexual Assault Nurse Evaluation (SANE) skills.

The initial evaluation includes rapid access to treatment by a specialized clinical team, assessment and treatment of bodily injuries with a focus on genital trauma, psychological assessment and support, pregnancy assessment and prevention, preventive treatment of STDs, and collection

of forensic data, including toxicology testing for the presence of date-rape drugs.

When sexual assault is reported, treat for an STD. The Centers for Disease Control and Prevention (CDC) recommends the following approach to prevent and treat STDs in victims of sexual assault²³:

- ceftriaxone 125 mg IM to prevent gonorrhea
- azithromycin 1 g orally as a single dose or doxycycline 100 mg twice daily for 7 days to prevent chlamydia

CONTINUED ON PAGE 32

- metronidazole 2 g orally as a single dose to prevent trichomoniasis
- hepatitis B vaccination, for women not previously vaccinated. (The CDC recommends against the use of hepatitis B immune globulin as the costs are believed to outweigh the benefits.)
- HIV postexposure prophylaxis for 3 to 7 days, with a follow-up visit to consider pros and cons of continued prophylaxis. (The risk of HIV infection following a sexual assault is low.)
- postcoital contraception (for example, levonorgestrel 1.5 mg orally as a single dose).

An antiemetic also should be offered to reduce the risk that the multiple prescribed medications will cause vomiting and nullify prophylaxis efforts. Approximately 2 weeks after the sexual assault the patient should have a pregnancy test and be assessed for ongoing mental health needs. If she did not adhere to the medications or if she shows relevant symptoms, perform follow-up STD testing. Follow-up HIV and syphilis testing can be performed at 12 and 24 weeks following the assault.

Sexual dysfunction

Sexuality is an important part of the human experience. Sexual dysfunction is the inability to participate as desired in a sexual relationship. Problems of sexual dysfunction are best approached from a biopsychosocial framework that recognizes the important contributions of biological, psychological, and social-cultural factors in sexual health. Masters and Johnson posited four stages of sexual response: excitement, plateau, orgasm, and resolution. Building on this linear model, investigators later divided the excitement phase into desire and arousal.

Recent models of sexual response have emphasized a circular model, in which sequential responses overlap and build on previous stimuli. These models also emphasize the importance of emotional intimacy and the quality of the relationship in achieving optimal sexual health.

Approximately 40% of women and 30% of men report sexual dysfunction.²⁴ Common

sexual problems reported by heterosexual women include:

- lack of interest in sex
- inability to achieve orgasm
- pain caused by sexual intercourse
- lack of pleasure with sex
- trouble lubricating.

The majority of men and women will not voluntarily report sexual dysfunction to their clinician. **To elicit the presence of sexual concerns, you must initiate the conversation.**²⁵ You can begin the sexual history by asking, “Do you have any concerns about your sex life?” Additional helpful, open-ended questions include: “Are you having sexual relations currently? With men or women or both?”, “If you are not having sex, when did you last have intercourse?”, “Are you satisfied with the frequency and quality of your sexual experiences?”, “What is the emotional quality and intimacy of your relationship with your sex partner?”

The common sexual disorders in women are categorized as desire, arousal, orgasm, and pain disorders. There are two **desire disorders**: hypoactive sexual desire disorder and sexual aversion disorder. There are two **arousal disorders**: female sexual arousal disorder and persistent genital arousal disorder. There are four **pain disorders**: dyspareunia, vulvodynia, vaginismus, and noncoital nonsexual pain.

Most experts recommend that treatment of female sexual dysfunction include multiple modalities that reflect the complex biopsychosocial factors that cause the problem. For example, a treatment plan might include cognitive behavioral therapy, sex therapy, and appropriate medications.

Mental health issues

Depression, anxiety, bulimia, and anorexia nervosa are more common in women than men. For instance, the lifetime risk of depression in women is approximately 20%, compared with about 10% in men. The gender difference is first observed in adolescence and becomes minimal after age 60. The gender differences are observed across racial and ethnic groups.²⁶



You must initiate the conversation about sexual health, and document and follow-up

It's on us

As leaders in women's health care, we are uniquely trained to guide, counsel, diagnose, and treat women across their entire lifetime, from adolescence to postmenopause. We are at the vanguard in the effort to continually improve the health of all women. 🗣️

References

1. American College of Obstetricians and Gynecologists Committee on Gynecologic Practice. ACOG Committee Opinion No. 483. Primary and preventive care: periodic assessments. *Obstet Gynecol*. 2011;117(4):1008-1015.
2. Diaz A, Laufer MR, Breech LL; American Academy of Pediatrics Committee on Adolescence, American College of Obstetricians and Gynecologists Committee on Adolescent Health Care. Menstruation in girls and adolescents: using the menstrual cycle as a vital sign. *Pediatrics*. 2006;118(5):2245-2250.
3. Stewart FH, Harper CC, Ellertson CE, Grimes DA, Sawaya GE, Trussell J. Clinical breast and pelvic examination requirements for hormonal contraception: current practice vs evidence. *JAMA*. 2001;285(17):2232-2239.
4. Finer LB, Jerman J, Kavanaugh ML. Changes in use of long-acting contraceptive methods in the United States, 2007-2009 [published online ahead of print July 13, 2012]. *Fertil Steril*. doi:10.1016/j.fertnstert.2012.06.027
5. Population Division, Department of Economic and Social Affairs, United Nations. World Contraceptive Use, 2011. http://www.un.org/esa/population/publications/contraceptive2011/wallchart_front.pdf. Published April 2011. Accessed September 15, 2012.
6. Trussell J, Lalla AM, Doan QV, Reyes E, Pinto L, Gricar J. Cost effectiveness of contraceptives in the United States. *Contraception*. 2009;79(1):5-14.
7. Secura GM, Allsworth JE, Madden T, Mullersman JL, Peipert JF. The contraceptive CHOICE Project: reducing barriers to long-acting reversible contraception. *Am J Obstet Gynecol*. 2010;203(2):115.e1-7.
8. Miller CW, Ford CA, Morris M, et al. Prevalence of chlamydial and gonococcal infections among young adults in the United States. *JAMA*. 2004;291(18):2229-2236.
9. Roger VL, Go AS, Lloyd-Jones, et al; American Heart Association Statistics Committee and Stroke Statistics Subcommittee. Heart disease and stroke statistics—2011 update: a report from the American Heart Association. *Circulation*. 2011;123(4):e18-e209.
10. Krystal AD. Insomnia in women. *Clin Cornerstone*. 2003;5(3):41-50.
11. Ensrud KE, Stone KL, Blackwell TL, et al. Frequency and severity of hot flashes and sleep disturbance in postmenopausal women with hot flashes. *Menopause*. 2009;16(2):286-292.
12. Strawbridge WJ, Cohen RD, Shema SJ, Kaplan GA. Successful aging: predictors and associated activities. *Am J Epidemiol*. 1996;144(2):135-141.
13. Mosca L, Benjamin EJ, Berra K, et al; American Heart Association. Effectiveness based guidelines for the prevention of cardiovascular disease in women—2011 update. *J Amer Coll Cardiol*. 2011;57(12):1404-1423.
14. Ridker PM, Cook NR, Lee IM, et al. A randomized trial of low-dose aspirin in the primary prevention of cardiovascular disease in women. *N Engl J Med*. 2005;352(13):1293-1304.
15. Steering Committee of the Physicians' Health Study Research Group. Final report on the aspirin component of the ongoing Physicians' Health Study. *N Engl J Med*. 1989;321(3):129-135.
16. Baigent C, Blackwell L, Collins R, et al; Antithrombotic Trialists' Collaboration. Aspirin in the primary and secondary prevention of vascular disease: collaborative meta-analysis of individual participant data from randomized trials. *Lancet*. 2009;373(9678):1849-1860.
17. U.S. Preventative Services Task Force. Aspirin for the prevention of cardiovascular disease. *Ann Int Med*. 2009;150(6):396-404.
18. Fang MC, Singer DE, Chang Y, et al. Gender differences in the risk of ischemic stroke and peripheral embolism in atrial fibrillation: the AnTicoagulation and Risk factors In Atrial fibrillation (ATRIA) study. *Circulation*. 2005;112(12):1687.
19. Mannino Dm, Homa DM, Akinbami LJ, Ford ES, Redd SC. Chronic obstructive pulmonary disease surveillance—United States, 1971-2000. *MMWR Surveill Summ*. 2002;51(6):1-16.
20. Bolland MJ, Grey AB, Gamble GD, Reid IR. Effect of osteoporosis treatment on mortality: a meta-analysis. *J Clin Endocrinol Metab*. 2010;95(3):1174-1181.
21. Brauer CA, Coca-Perrillon M, Cutler DM, Rosen AB. Incidence and mortality of hip fractures in the United States. *JAMA*. 2009;302(14):1573-1579.
22. Centers for Disease Control and Prevention. Adverse health conditions and health risk behaviors associated with intimate partner violence—United States, 2005. *MMWR*. 2008;57(9):113-117.
23. Workowski KA, Berman SM; Centers for Disease Control and Prevention. Sexually transmitted diseases treatment guidelines, 2006. *MMWR*. 2006;55(RR-11):1-94.
24. Laumann EO, Nicolosi A, Glasser DB, et al; GSSAB Investigators' Group. Sexual problems among women and men aged 40 to 80 years, prevalence and correlates identified in the Global Study of Sexual Attitudes and Behaviors. *Int J Impot Res*. 2005;17(1):39-57.
25. Nusbaum MR, Helton MR, Ray N. The changing nature of women's sexual health concerns through the midlife years. *Maturitas*. 2004;49(4):283-291.
26. Gutierrez-Lobos K, Scherer M, Anderer P, Katschnig H. The influence of age on the female/male ratio of treated incidence rates in depression. *BMC Psychiatry*. 2002;2:3.

"We are at the vanguard in the effort to continually improve the health of all women."

—Robert L. Barbieri, MD