



Providing Gynecologic Care to the Developmentally Disabled

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Objectives

- After this lecture, the participant will be able to:
 - Define and identify principles involved with the healthcare for the developmentally delayed woman
 - Conduct a reproductive health evaluation in this group of women
 - Manage some specific gynecological issues including: pap smears, menstrual problems, contraception

Definitions

- **Developmental Disability**
 - Any chronic mental/physical condition that occurs before 22yo and is likely to cause limitations in 3+ areas
- **Retardation**
 - Subnormal general intellectual development originating during the developmental period. Further classified based on IQ

Developmental Disabilities Assistance and Bill of Rights Act of 2000

Philosophy of Care

- No exam should occur with excess force or with threat
- Ethical principles
 - Autonomy: personal rule of the self
 - Beneficence: promote well-being of others
 - Nonmaleficence: do no harm
 - Justice: rendering what is due others

ACOG, Ethics in Ob/Gyn, 2004

Principles of Management

- Treat each pt as a unique individual
- Treat gynecological concerns while keeping in mind that patient's medical, social and psychological needs
- Always choose the least disruptive appropriate care choice

History

- Depends on the degree of handicap and the knowledge of the attending caregiver
- Must have behavior and menstrual calendar
- Confidentiality
- Look for hidden agenda

Sexual Education

- Mild DD
 - Focus on understanding sexual identity and development
 - Acceptable social behavior
 - Private vs public body parts
 - Avoid situations that might put patient at risk of sexual assault

Sexual Education

- Mod/Severe DD
 - Personal hygiene
 - Avoid self abuse
 - Acceptable social behavior

Physical Exam-General

- Special Issues
 - Extreme anxiety due to multiple physician encounters
 - Possible history of abuse (10-30%)
 - Multiple physical handicaps requiring creative and flexible positioning
- Other considerations

Routine Gynecology Needs

- First pap smear and breast exam between 18yo and 21yo
- Breast imaging between 35yo and 40yo
- Yearly breast imaging by age 40
- Evaluation of Bone Density at age 50 or earlier if there are risk factors:
 - Hypoestrogenic state
 - Thyroid disease
 - (Immobility)
 - Explain exam, avoid using heel rests, (wear white coat)
- HPV vaccine 11-26yo

Common Gynecologic Problems

- Menstrual Irregularity
- Menstrual Pain (Dysmenorrhea)
- Hygiene Difficulties
- PMS
- Menses exacerbating other problems
 - Seizures
 - Aggression
- Contraception

Performing a Pelvic Exam

- Know your patient
- Take the time to train your staff
- Be flexible
- Never force a patient. If an adequate exam is necessary, consider performing an exam under anesthesia

Positioning for Pelvic Exam

- Traditional Dorsal Lithotomy
- Legs up with assist/Knee chest with assist
- Side lying



Irregular Menses

- Eugonadism
 - Estrogen levels are normal or high
- Hypogonadism
 - Estrogen levels are low

Irregular Menses Hypogonadism

- Hypogonadotropic
 - Reversible
 - Stress from illness, weight loss, emotional
 - Primary hypothyroidism
 - Hyperprolactinemia
 - Cushing's syndrome
 - Irreversible
 - Congenital deficiency syndromes
 - Anatomic lesions
- Hypergonadotropic
 - Ovarian failure

Irregular Menses-Evaluation

- PE to determine presence and patency of Müllerian structures, and estrogenization
- Lab evaluation
 - Wet prep
 - UCG
 - PRL
 - TSH
 - LH/FSH
 - (E2)
- Progesterone challenge

Irregular Menses-Evaluation

If Hyperandrogenic Chronic Anovulation (PCOS) is suspected:
consider checking for insulin resistance

Treatment-Ovulatory Dysfunction

- Goals of treatment
 - Prevent endometrial hyperplasia
 - Prevent anemia from hemorrhagic menses
 - Prevent hyperandrogenic symptoms
 - Acne, hirsutism
 - Prevent obesity, diabetes, CAD

Treatment-Hypogonadism

- Replace estrogen
 - OC's
 - Estrogen supplement
- Use progestins if there is an intact Müllerian system

Dysmenorrhea-Etiologies

- Primary (functional)- prostaglandin mediated
- Endometriosis
- Obstructing Müllerian Anomaly

Dysmenorrhea-History

- Menstrual history
- Timing of cramps
- PMS
- Associated nausea, vomiting, diarrhea
- How it impacts on daily life
- Medications used in past
- FH of dysmenorrhea, and endometriosis

Dysmenorrhe-PE

- Careful genital inspection
- +/- speculum exam
- Bimanual/recto-abdominal
- +/- ultrasound

Dysmenorrhea-Treatment

- Careful explanation of causes to caregiver and patient when appropriate
- Medication
 - NSAID's
 - Naproxen Sodium DS 550mg bid
 - Mefanamic acid 500mg stat, then 250mg q 6 hours
 - Ovulation Suppression with OCP's
 - Levonorgestrol IUD
 - Laparoscopy if unresponsive to medical management after 3-4 months

Hygiene Difficulties

In some patients, it is desirable to achieve amenorrhea. This can be done with continuous combined hormonal contraception, intramuscular DMPA every 10-12 weeks, or Levonorgestrol IUD

Hysterectomy rarely indicated

Premenstrual Syndrome

- Symptoms begin after ovulation and resolve with the onset of menses
 - Breast pain
 - Bloating
 - Food cravings
 - Worsening seizures
 - **Mood disturbance**

Management of PMS

- Treatment should be tailored to symptom
- Increase physical activity
- Increase water intake
- Increase in anxiolytics during this time
- Ovulation suppression

Menses Exacerbating Preexisting Conditions

- Approximately 50% seizure patients have worsening of their seizure activity during menses
- Patients with aggression will often have increase aggressive and self destructive behavior during menses
 - ❖Ovulation suppression is the most effective treatment of these problems

Contraception

- Progestin Only Contraception
 - Progestin only pill
 - DMPA
 - Levonorgestrol implants
- Combined Hormonal Contraception
 - OCP's
 - Patch
- Levonorgestrol IUD
- Tubal ligation

Progestin Only Contraception Advantages

- Fewer contraindications
- Reversible
- Low risk of ectopic pregnancy
- Decreased menstrual flow
 - Decreased cramps, anemia
- Decreased risk of ovarian and endometrial cancer
- Decreased PID

Progestin Only Contraception Disadvantages

- Less effective than combined hormonal contraception(oral only)
- Menstrual cycle irregularities
- Weight gain/bloating
- Breast tenderness
- depression

DMPA

- Advantages
 - Good compliance
 - Effectiveness >99%
 - Decreased sz in epileptic patients
 - Amenorrhea
- Disadvantages
 - Weight gain
 - Depression
 - Injection
 - Takes up to 1 year for return of fertility
 - Potential for bone demineralization

Combined Hormonal Contraception Non contraceptive Benefits

- Menstrual regulation
- Decreased flow
- Decrease dysmenorrhea
- Lowers risk of endometrial and ovarian cancer (rr 0.6)
- Lowers incidence of benign breast disease

Common Minor Side Effects

- Irregular bleeding for first three months
- Nausea
- HA
- Breast tenderness

Combined Hormonal Contraception Serious Side Effects

- Thrombophlebitis
- PE
- MI
- Gallbladder disease
- Hepatic adenomas
- Depression

Combined Hormonal Contraception Absolute Contraindications

- H/O thrombophlebitis or clotting disorder
- H/O CVA, MI, or CAD
- Known or suspected hormones sensitive Cancer
- History of breast cancer
- Known or suspected pregnancy
- Abnormal LFT's
- Undiagnosed vaginal bleeding

Combined Hormonal Contraception Relative Contraindication

- Over 35 and >15 cigarettes/day
- Migraines assoc with pills
- HTN with DBP of 90 or more
- Diabetes
- Sickle cell disease

Combined Hormonal Contraception Drug Interactions

- Decrease pill efficacy/decrease drug efficacy
 - Some anticonvulsants
 - Cholesterol lowering drugs
 - Rifampin
 - Sedative hypnotics
 - Griseofulvin
 - (antibiotics)

Combined Hormonal Contraception Drug Interactions

- Increase serum levels of corticosteroids
- Increase sedative effect of TCA
- Increase phenothiazine levels
- Increase levels of bronchodilators

Levonorgestrol IUD

- Available in Europe since 1992, an US since 2001
- Over 8 million users
- 99.9% effective
- Significantly decreases menstrual flow
- Does not interfere with other medications
- May need anesthesia for insertion
- Good for 10 years

How to Choose a Method

- Ease of use
- Reliability of patient
- Caregiver involvement
- STD protection

Menopause

- Screen for osteoporosis in all postmenopausal patients
- Treat with ERT only if there is a concern regarding menopausal symptoms

Remember, compassionate
and quality healthcare is
everyone's right