Pediatric & Adolescent Gynecology Pearls

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Disclosures

- I have no commercial, proprietary or financial interests/relationships to disclose
- The opinions and assertions contained in this presentation are my private views and are not to be construed as official or as reflecting the views of the University of Utah or Primary Children's Hospital

Objectives

- Troubleshoot the gynecologic management of selected younger patients
- Increase knowledge for diagnosing and managing several basic pediatric/adolescent complaints
- Identify when referral to a pediatric gynecologist is the most appropriate course of action

What is PAG?

- Full range of gynecology
- Includes ages 0-18, with some exceptions to 21/22
- Medical and surgical
- Doesn't routinely include obstetrical care
- Participation in multi-disciplinary clinics

Pearl #1: Yeast Infections

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- The Reality:
  - Prepubertal children that are out of diapers rarely have yeast infections

Common Complaints

- Redness
- Itching
- Burning
- Pain
- Feels weird
- Looks funny

What Contributes?

- Low estrogen levels
- High pH (6.5-7.5) – more alkaline than post-puberty
- Lack of hair and fat pads (labia)
- Proximity of vagina to anus
- Hygiene (independence)
- External irritants
- Clothing choices

Vulvovaginitis (VV)

Yeast

- Rarely seen when not in diapers (or post-pubertal)
- If yeast is diagnosed, consider immunocompromised states
- Prepubertal vaginal pH is alkaline which is hostile to yeast

Non-specific VV

- 25-75% of vulvovaginitis complaints
- Hygiene measures
- Consider pinworm (can treat empirically)
- Obtain vaginal culture

Pearl #2: OCPs and Bone Health

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- The Premise:
  - Teens are young, so using low or very low dose OCPs will be best for them
- The Reality:
  - Using 10 or 20 mcg pills can actually prevent appropriate bone accrual

Pearl #2: OCPs and Bone Health

- Adolescent years are critical for peak bone mass acquisition
  - Approximately 40% of adult bone mass is accrued during adolescence
  - By age 19, approximately 95% of peak bone mass has been accrued
- Hormonal status is a major determinant of bone health

Pearl #2: OCPs and Bone Health

- COCs remain the most popular method among adolescents
- Prospective studies demonstrated that adolescents on 30-35 mcg gained BMD but at lower rates than non-users
- Another RCT demonstrated significantly lower accrual in patients using 20 mcg pills (compared to 30 mcg or placebo)

Pearl #2: OCPs and Bone Health

- A quick word about DMPA
- SAHM recommends continued prescribing but also discussing risks/benefits
- ACOG states use should not be limited to 2 years but clinical judgement should be used

Pearl #3: Teens & Endometriosis

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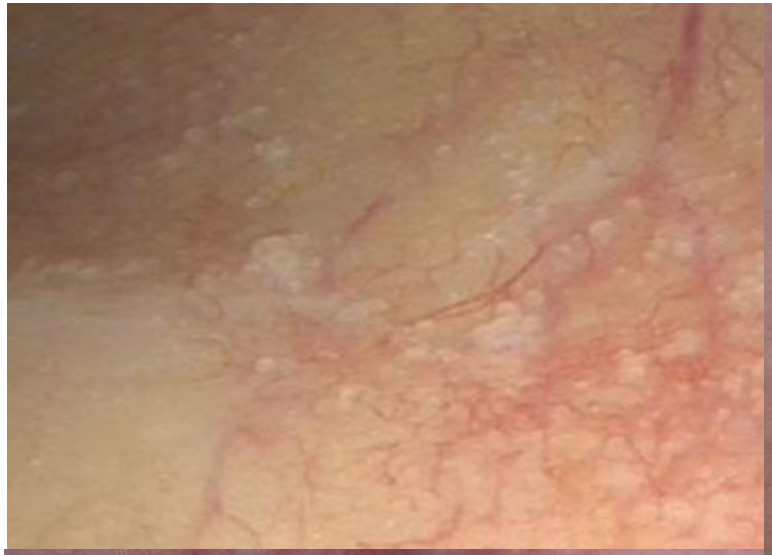
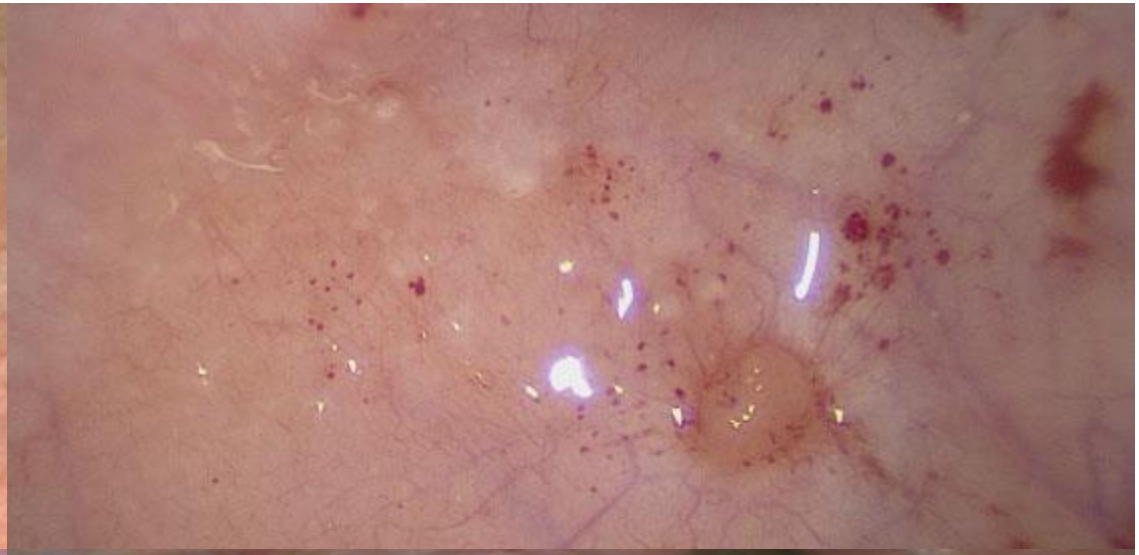
- The Premise:
  - One must menstruate for many years before they are able to develop endometriosis. Also, teens are whiny and just don't want to go to school.
- The Reality:
  - At least 2/3 of patients with persistent pain on hormone medication will have endometriosis

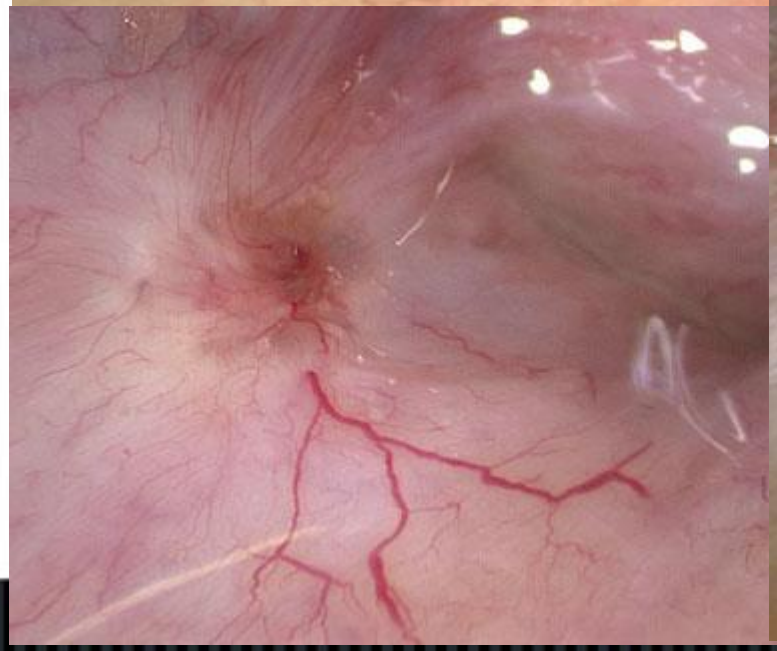
Some Background

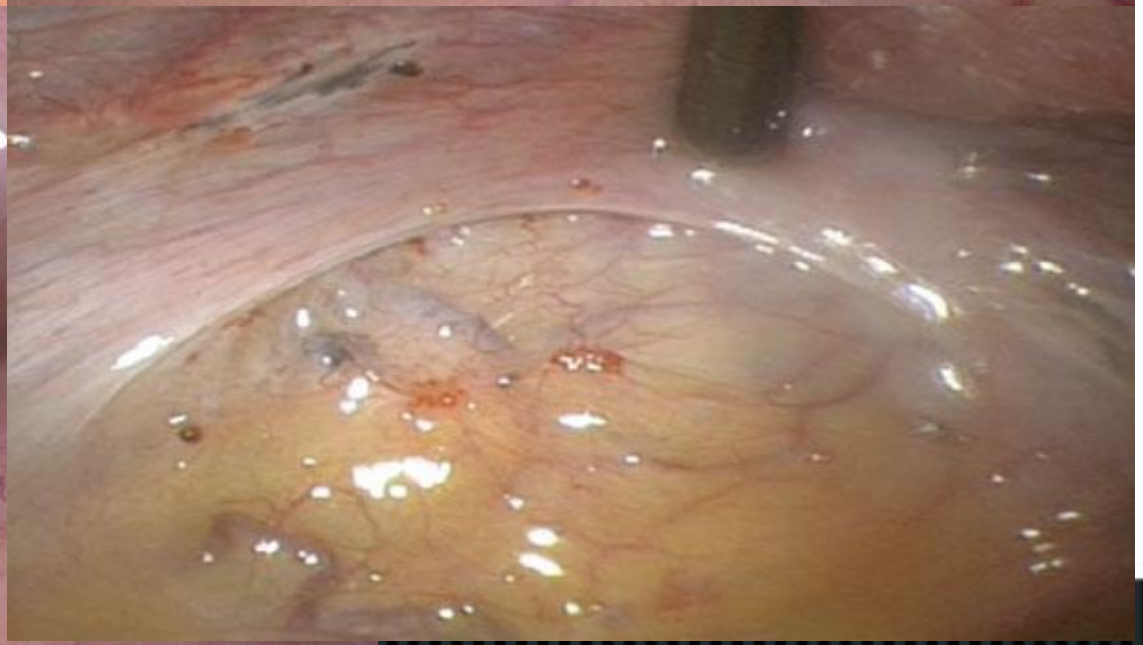
- “The typical patient with endometriosis is in her mid-30s, is nulliparous and involuntarily infertile, and has symptoms of secondary dysmenorrhea and pelvic pain.”
- “Endometriosis in teenagers should be investigated for obstructive reproductive tract abnormalities that increase the amount of retrograde menstruation.”
- “The disease is usually first diagnosed in a woman during her mid to late 20s.”

Lobo RA. Endometriosis: Etiology, Pathology, Diagnosis, Management. In: *Comprehensive Gynecology*. 5th ed. Mosby Elsevier; 2001:473-499.









Adolescent Endometriosis

- Lesions often appear different than in adults
- Missing school for menstrual pain is NOT normal
- Diagnosis occurs an average of 6.7 years after symptom onset
- Primary complaint is pain, not infertility
- Must consider müllerian anomalies, but not most common cause

Pearl #4: Teens and IUDs

- The Premise:
  - Those who haven't had a baby (or sometimes, those who haven't had intercourse or haven't used a tampon) can't have an intrauterine device (IUD)

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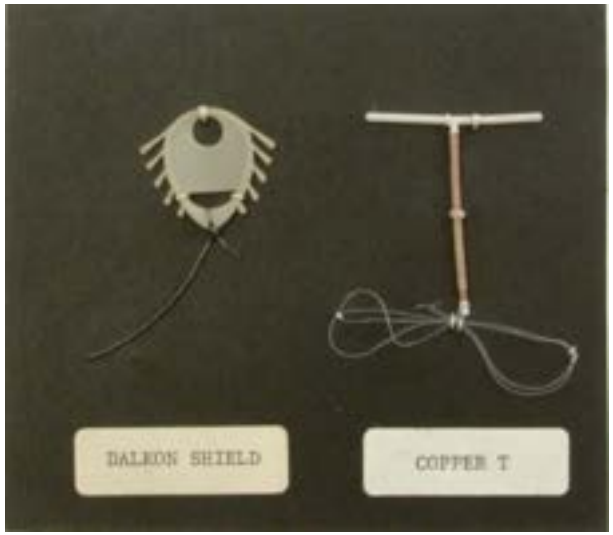
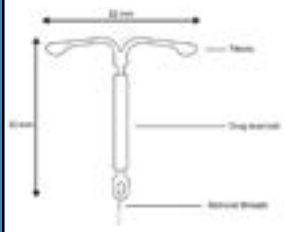
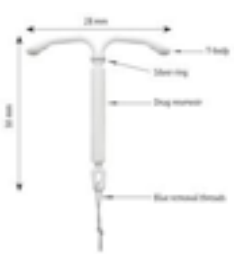
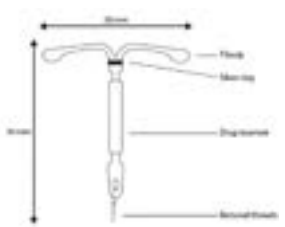
- The Premise:
  - Those who haven't had a baby (or sometimes, those who haven't had intercourse or haven't used a tampon) can't have an intrauterine device (IUD)
- The Reality:
  - Most individuals who are menstruating are candidates for IUDs

Some Background

- Product labeling in package inserts
- Bad press from the Dalkon shield
- Culture concerns
- Social media and online "reviews"



	INTRATUERINE DEVICES AVAILABLE IN USA				
	Levonorgestrel IUD				Copper IUD
	Mirena™	Liletta™	Kyleena™	Skyla™	Paragard™
					
Approved for:	8 years (5)	7 years (5)	5 years	3 years	10 years
Total Hormone	52 mg	52 mg	19.5 mg	13.5 mg	0 mg (NA)
Daily Dose	20 mcg/d	20 mcg/d	17.5 mcg/d	14 mcg/d	0 mcg/d (NA)
String Color	Brown	Blue	Blue	Brown	White
Silver Ring Present	N	N	Y	Y	N
Indications Besides Contraception	Heavy menstrual bleeding	Heavy menstrual bleeding	None	None	None

Adolescents & IUDs

- ACOG and AAP recommend as first-line contraception
- Copper IUD has a slight increased risk of expulsion
- Methods for placement
- Appropriate anticipatory guidance

QUESTIONS?

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