Women’s health
Women’s health
Unit 509 September 2014

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The five domains of general practice
- Communication skills and the patient-doctor relationship
- Applied professional knowledge and skills
- Population health and the context of general practice
- Professional and ethical role
- Organisational and legal dimensions

RACGP
ABOUT THIS ACTIVITY

Social/cultural roles and expectations of women, as well as biological factors, can affect women’s health and wellbeing. Issues of particular concern for women’s physical and mental health include perinatal problems and disorders arising from hormonal imbalances. Violence against women, a major human rights abuse that may lead to physical, mental, sexual, reproductive health and other health problems, is also a key area of concern. Worldwide, about 35% of women have experienced intimate partner violence or non-partner sexual violence in their lifetime and about 38% of murdered women are killed by an intimate partner. In Australia, one in three women has been exposed to physical violence, and one in five women aged over 15 years has experienced sexual violence. This edition of check will consider scenarios of relevance to the management of women’s health in general practice.

LEARNING OUTCOMES

At the end of this activity, participants will be able to:

- outline the management options for women with perinatal depression
- list strategies for the management of vaginismus
- summarise the diagnosis and management of polycystic ovary syndrome
- discuss useful strategies for managing women suspected of experiencing domestic violence
- describe the medical management of a woman who has been raped.

AUTHORS

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PEER REVIEWERS

Elizabeth Hindmarsh MBBS, FRACGP is a general practitioner who worked in an inner city practice for 28 years. Following this Dr Hindmarsh worked in Aboriginal health in a remote community in NT and, more recently, has been in an Aboriginal practice in outer Sydney. She has contributed to projects for the RACGP for about 24 years in the area of abuse and violence and is an editor of the RACGP White book 4th edition. Dr Hindmarsh is a co-chair on the RACGP Specific Interest group – Abuse and Violence.

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REFERENCES

GUIDE TO ABBREVIATIONS AND ACRONYMS IN THIS UNIT OF CHECK

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tbody>
<tr>
<td>BMI</td>
<td>body mass index</td>
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<tr>
<td>CAH</td>
<td>congenital adrenal hyperplasia</td>
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<tr>
<td>CBT</td>
<td>cognitive behaviour therapy</td>
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<tr>
<td>COC</td>
<td>combined oral contraceptive</td>
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<tr>
<td>DSM-5</td>
<td>Diagnostic and Statistical Manual of Mental Disorders 5th edition</td>
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<tr>
<td>EPDS</td>
<td>Edinburgh Postnatal Depression Scale</td>
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<tr>
<td>FAI</td>
<td>free androgen index</td>
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<tr>
<td>FSH</td>
<td>follicle stimulating hormone</td>
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<td>GDM</td>
<td>gestational diabetes mellitus</td>
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<td>HBV</td>
<td>hepatitis B virus</td>
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<tr>
<td>β-hCG</td>
<td>β-human chorionic gonadotropin</td>
</tr>
<tr>
<td>HCV</td>
<td>hepatitis C virus</td>
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<tr>
<td>HDL-C</td>
<td>high-density lipoprotein cholesterol</td>
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<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
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<tr>
<td>LDL-C</td>
<td>low-density lipoprotein cholesterol</td>
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<tr>
<td>OGTT</td>
<td>oral glucose tolerance test</td>
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<tr>
<td>PCOS</td>
<td>polycystic ovary syndrome</td>
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<tr>
<td>PCR</td>
<td>polymerase chain reaction</td>
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<tr>
<td>SHBG</td>
<td>sex hormone-binding globulin</td>
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<tr>
<td>SSRI</td>
<td>selective serotonin reuptake inhibitor</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmissible infection</td>
</tr>
<tr>
<td>T2DM</td>
<td>type 2 diabetes mellitus</td>
</tr>
<tr>
<td>TSH</td>
<td>thyroid stimulating hormone</td>
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<tr>
<td>VVS</td>
<td>vulvar vestibulitis syndrome</td>
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About this activity: This page is part of a document related to women’s health and includes a guide to abbreviations and acronyms used in the text. The references section lists sources used in the document, including works from the World Health Organization and the Australian Department of Social Services.
JENNY IS FINDING BEING A NEW PARENT DIFFICULT

Jenny is a primary school teacher aged 38 years. She is married and has a daughter, Chloe, aged 2 months. She has been seeing you regularly for PAP smears and contraception, and twice for minor issues during her recent first pregnancy. She presents today with Chloe. You know that Jenny has no past history of any serious illness. Her mother had depression throughout Jenny's childhood years and her grandmother had bipolar disorder. Jenny says Chloe is not sleeping and feeds ‘constantly’. She is fully breastfeeding and aspires to attachment parenting (ie understanding and responding to Chloe's emotional and physical needs and building a strong relationship with Chloe). Chloe’s chart from the health centre shows she is on the 35th percentile for height and weight and has been since birth. Jenny looks tired, despite having makeup on, but says she is doing fine and that Chloe's routine is the problem.

QUESTION 1
What issues need exploration in this consultation?

FURTHER INFORMATION
Jenny denies being depressed but admits that her husband says she is irritable. He works long hours and doesn’t provide much help. Jenny has cried on most days in the past month and says she is sleeping no more than 4 hours per night and cannot get back to sleep after Chloe wakes her. Her concentration is low and she is not enjoying anything. She says, ‘motherhood is nothing like I imagined’. She worries that Chloe has allergies and has been searching the internet for causes of crying in babies. Jenny and Chloe’s physical examinations are normal and Jenny denies any thoughts of harm or excessive fears. She is agreeable to your suggestion of having her mother stay with her to care for Chloe overnight so she can sleep.

At her next appointment 3 days later, which her husband does not attend because he is too busy at work, Jenny is still not sleeping, although she had an extra hour of sleep when her mother stayed over, and she feels she cannot cope. She starts crying in the consultation.

QUESTION 2
What is the most likely diagnosis? What are your treatment options?

FURTHER INFORMATION
Jenny agrees to see a psychologist for cognitive behaviour therapy (CBT) and her mother has agreed to look after Chloe on 3 days a week so Jenny can rest and go to yoga. When she sees you 2 weeks later, Jenny has had two CBT sessions and seems more anxious. Sleep remains a problem. She admits to having intrusive thoughts more frequently; for example, she fears that something will happen to Chloe and that it will be her fault. On closer questioning she fears she will put Chloe in the microwave by mistake or drop her in the bath. These thoughts horrify her and although she does not believe she would ever act on these thoughts, she thinks she must be the ‘worst ever’ mother for having them. She is getting her husband to bath the baby and has disconnected the microwave.

QUESTION 3
How are you going to manage Jenny?
CASE 1 ANSWERS

ANSWER 1
Chloe is the presenting issue; however, given Jenny’s family history and her tired appearance there is a potential underlying issue with Jenny, although she has hinted that she is reluctant to accept that she might have any problems.1 Examine Chloe first and rule out any underlying physical disorder, noting how well she is doing. At the same time, tell Jenny that the first few months of motherhood can be tough and that most women find it difficult (ie normalise). Ask Jenny if she has any breaks, how much sleep she is actually getting and if there is anyone who can care for Chloe overnight to give her a break. In particular, ask what role her husband is having and, if not much, whether he could be involved more. Suggest that he comes to the next appointment. You could also ask Jenny if her mother is able to help and whether she has other support networks, particularly other women with babies or young children. Consider any lifestyle issues, such as diet, drugs and alcohol, that might be contributing to her tiredness and suggest that some gentle exercise might help (eg walking with the pram).

You should ask if she has completed an Edinburgh Postnatal Depression Scale (EPDS)2 with her child health nurse. If she has, you could ask her about her score. A score of 10 or more is suggestive of possible depression.2 It is important to say how common it is for women to feel a bit down after the birth of a child and to ask Jenny how she is feeling. You could reassure Jenny that feeling tired is normal.

Jenny is still in the high-risk time frame for depression and postpartum psychosis,3 both of which can be exacerbated by sleep deficit. You need to complete a psychiatric history, concentrating on depressive symptoms, psychotic symptoms, particularly related to whether her ideas about Chloe are realistic or if she has excessive concerns about her child’s health, as well as undertaking a risk assessment with respect to suicide and infanticide (including neglect and distraction through tiredness).

Checking for physical issues such as mastitis, urinary tract infection and thyroid dysfunction may also be warranted.

ANSWER 2
If Jenny’s physical tests are normal, she most probably has postnatal depression, which, according to the Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5),4 may be an adjustment disorder or major depression. Psychotic depression, postpartum psychosis or a variation of bipolar disorder are diagnoses that need to be considered given her high level of anxiety, sleeplessness and her family history. The latter needs to be clarified. Her risk for major depression includes her family history, having a first baby and being an older mother.5 She has already given you indications that she feels she has failed, that her baby is not perfect and that motherhood is not what she expected.

FURTHER INFORMATION
You prescribe sertraline, up to 200 mg, after discussion with the psychiatrist to whom she has been referred. Jenny’s condition improves significantly after 3 months. She is now sleeping for 6 hours per night on most nights and only occasionally has intrusive thoughts. She takes 200 mg sertraline daily. She has weaned Chloe. She has seen the psychiatrist three times in the past 2 weeks ago and has an appointment in 2 weeks. She has stopped seeing the psychologist but says she finds some of the techniques helpful. She tells you that she still does not enjoy motherhood and is thinking about going back to work. She fusses over Chloe throughout the consultation and the child is irritable. Jenny tells you Chloe is ‘always like that’ and at playgroups Chloe never leaves Jenny’s side. She says ‘it’s exhausting’.

QUESTION 4 🥰
Is there anything else you need to do at this time?

FURTHER INFORMATION
Jenny is now 18 months postpartum and has been back to her normal self for 6 months. She never attended any extra therapy and now that Chloe is in a routine she feels everything is fine. She is working as an emergency teacher and now wants to stop her medication and have another child.

QUESTION 5 🥰
What are your recommendations?
Reiterate that mood problems are common in the postpartum period. For example, a beyondblue postnatal depression screening program reported that 16% of women have depression in the postnatal period and many more have high scores on the EPDS due to adjustment difficulties. Tell Jenny that women improve with time and treatment. Rebalancing expectations will be an ongoing part of any consultation.

Outline treatment options, starting with non-medication strategies. For example, suggest taking breaks from Chloe, perhaps by asking her mother to babysit on a regular basis or, alternatively, using paid childcare. This could be discussed with the reflection that ‘it takes a village to raise a child’. Address any other lifestyle issues identified as possible contributing factors. Another option is cognitive-behavioural therapy (CBT) with a psychologist or in a group setting (often run at child health centres), which may be supportive and/or therapeutic. CBT is one of several psychological therapies reported to have moderate-quality evidence supporting improved symptoms in postnatal depression. Other options include interpersonal psychotherapy and psychodynamic therapy. Recommend useful, vetted websites (see Resources for patients) and discourage the use of other websites. Ideally, provide Jenny with some fact sheets, for example, from beyondblue and the Post and Antenatal Depression Association (PANDA), and the PANDA hotline. With Jenny’s permission, contact her husband if he is unable to attend an appointment and look at ways he may be able to help.

Introduce the idea of medication as another treatment possibility. Use of temazepam for a few days could be useful. Jenny is likely to be worried about addiction and transfer of medication to the baby via her breast milk; this is minimal with 10–20 mg temazepam and for 2–3 days only. Given that her current history has now persisted for more than 1 month, you could suggest a selective serotonin reuptake inhibitor (SSRI) such as sertraline, which is reported to be present in low concentrations in breast milk, has little transfer to the infant and poses few risks of side effects in the child. The Australian Medicines Handbook 2014 indicates that some people consider sertraline to be one of the preferred antidepressants for use when breastfeeding and suggests using it as an alternative to fluoxetine, which has a long half-life. In general, SSRIs (Australian pregnancy category C), with the exception of paroxetine, are considered relatively safe for use in pregnancy and the postnatal period; paroxetine (Australian pregnancy category D) should be avoided in women of child-bearing potential. Warn Jenny that the medication could make her more agitated but it will not sedate her, so she will still be able to care for Chloe. If she has bipolar disorder there is a risk that an antidepressant could cause mania if she is not on a mood stabiliser.

ANSWER 3
A referral to a perinatal psychiatrist is now critical and if an appointment cannot be obtained urgently then the GP should ring and get telephone advice regarding medication. An antidepressant is now likely to be effective if it has not already begun as Jenny may now have a major depressive disorder with obsessional thoughts. Obsessive-compulsive disorder is a possible differential diagnosis. Psychosis is less likely given the intrusive thoughts are ego-dystonic (distressing, unacceptable) and that she avoids any possibility of doing them. Given the family history, bipolar disorder is a possibility but, statistically, it is more likely in the first 3 months (particularly in the first week).

If Jenny’s anxiety continues to be a major feature (and it is often the last symptom to improve) then continuing CBT will be important; exercise and yoga might also help. She may require a higher dose of the SSRI. Often, anxious women struggle with breastfeeding and having enough milk, which in turn causes the child to be more unsettled so wearing or a supplementary night feed may be an option worth discussing with Jenny, particularly if infant weight gain or breastfeeding has been an issue for her.

If Jenny’s symptoms worsen or do not begin to improve, consider a referral to a mother–baby unit if this is available.

ANSWER 4
It seems that Jenny’s depression is resolving but her lack of enjoyment may still be a feature of her illness. It may also be part of the driving stress; that is, there is an underlying attachment difficulty and Chloe’s birth and their relationship have rekindled her own early attachment difficulties when her mother had depression and was emotionally unavailable during her childhood. Ask Jenny how depressed her mother was (eg was she hospitalised?) and about their relationship, particularly when Jenny was little; did she feel she could go to her mother for comfort and did her mother help her to become independent and allow her to try things on her own? Are Jenny’s attachment problems with her mother being repeated with Chloe? If so, or if this lack of enjoyment persists, consider discussing with her psychiatrist about sending Jenny to a perinatal psychiatrist, mother–infant therapist or mother–infant therapy group (eg Circle of Security).

ANSWER 5
Jenny is at a higher risk of having another depressive episode postpartum, compared with someone who has never had postpartum depression, and her risk of having another depressive episode will be higher still (and possibly occur earlier) if she ceases her medication. Ideally, she should be well for 12 months before ceasing her medication, but as she has been taking it for this long, and given her age, she may not want to wait any longer before trying for another baby. Planning the next pregnancy with a perinatal psychiatrist is essential.

Table 1. Recommendations for making treatment choices for women with mental health issues who are planning a pregnancy, are pregnant or are breastfeeding

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<td>• choose medications with lower risk profiles for both the mother and the fetus/infant</td>
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<td>• initiate medication at low dose and titrate slowly to the lowest effective dose (to minimise dose-related risks)</td>
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<td>• use monotherapy in preference to combination treatment</td>
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The risks and benefits of ceasing or continuing medication need to be outlined and discussed, ideally with both Jenny and her husband. Current evidence indicates that an SSRI such as sertraline (avoid paroxetine and fluoxetine, although any increase in risk from them is small) has low risk for malformation and pulmonary hypertension of the newborn; registry studies have significant confounding variables such as higher alcohol and multiple drug use in women who take antidepressants. As a comparison, the risk of birth defects in the general population is 2–4%. There is a risk of slight prematurity (and possibly miscarriage), neurobehavioural delays and possibly autism but this also exists to a lesser extent in women with depression and anxiety. Women who are depressed and anxious in pregnancy (and not taking SSRIs) have infants born with higher cortisol levels, and may be more likely to be at risk of later behavioural, mood and anxiety disorders, as well as poor antenatal care and suicide.

If Jenny chooses to cease her medication, she should do so as slowly as possible (ideally over 6 months) and she should be monitored for symptoms of discontinuation and/or withdrawal, and signs of relapse. Taking a reduced dose might be an option, and discussion regarding how to manage a relapse is important in advance. A refresher course of CBT and discussion of general measures, such as keeping Jenny’s stress levels low, having regular sleep and engaging in regular exercise, are important regardless of whether she decides to stay on her medication or ceases using it.

REFERENCES


RESOURCES FOR PATIENTS

• PANDA, 1300 726 306, www.panda.org.au

• beyondblue, 1300 224 636, www.beyondblue.org.au

• The Royal Women’s Hospital Perinatal Psychotropic Information Centre, 03 8345 3190, www.ppmis.org.au

RESOURCES FOR DOCTORS

• The Royal Women’s Hospital Perinatal Psychotropic Information Centre 0383453190, www.ppmis.org.au

• beyondblue, 1300 224 636, www.beyondblue.org.au
CASE 2

CHERYL IS FRIGHTENED OF HER HUSBAND

Cheryl, 37 years of age, has made an urgent appointment and has specifically asked to see you. She looks white and drawn. She tells you that her husband Bob was particularly nasty and demeaning in an argument with her last night. When he came to bed she was exhausted and did not want to have sex but he was insistent. Cheryl was frightened and says she feels ‘if I had said no, he would have taken it anyway.’

QUESTION 1 📜

How would you respond to Cheryl?

FURTHER INFORMATION

You ask Cheryl to tell you more about her relationship with Bob. She says there has been ‘trouble’ in the past. When invited to say more, Cheryl tells you that Bob has episodically ‘lost his cool’. It started when she was pregnant with their daughter Kate. On one occasion Bob beat her and choked her. In the past year Bob has hit out at Cheryl again, knocking her against the door and/or floor. Bob is usually very sorry after it happens. She then tells you Bob is a good father and that Kate loves her dad and is happy in her school.

QUESTION 2 📜

Is Cheryl experiencing domestic violence? How prevalent is domestic violence?

QUESTION 3 📜 📜 📜

What should be documented during Cheryl’s visit? Why is it important to make notes of this visit?

FURTHER INFORMATION

Cheryl says she is concerned about who could access the information if it were to be recorded in her medical notes. She is worried and very embarrassed at the thought of other staff reading it when she comes back to the practice for routine medical matters.

QUESTION 4 📜 📜 📜

How can you protect a patient’s medical records?

QUESTION 5 📜

What are the most immediate concerns at this time? What important facts would you want to obtain from a further history?
Careful thought needs to be given to the response and approach to questioning in a situation such as this where a patient has indicated possible intimate partner abuse. GPs may lack confidence in discussing issues related to domestic violence and/or perceive that they cannot help abused women. However, studies have shown that patients want to be asked to discuss abuse and are likely to disclose abuse to their GP, particularly if asked directly and in a sensitive, empathic way. The Royal Australian College of General Practitioners (RACGP) publication, Abuse and violence: working with our patients in general practice (the white book), provides guidance about inquiry and disclosure of abuse.

Cheryl has disclosed what seems to be an abusive situation. A helpful response incorporates the following two steps from the ‘nine Rs’ for intervention described in the RACGP white book:

• recognising symptoms of abuse and violence, and asking directly and sensitively
• responding to disclosures of violence with empathic listening and exploration.

It is important to acknowledge Cheryl’s fears; you could respond by saying that what happened sounds very frightening for her but that she has been brave in disclosing her experience to you.

Examples of other questions or statements, which are open and likely to allow Cheryl to give a fuller history include the following:

• I am hearing you say you were frightened of what your husband would do if you did not have sex with him.
• Can you tell me more about your relationship with your partner?
• Has anything like this happened before?

The RACGP white book also suggests following up with more specific questions and statements:

• Has your partner ever physically threatened or hurt you?
• Is there a lot of tension in your relationship? How did you resolve the argument?
• Sometimes partners react strongly in arguments and use physical force. Is this happening to you?
• Have you ever felt unsafe in the past?
• Violence is very common in the home. I ask a lot of my patients about abuse because no one should have to live in fear of their partners.

Responses that are not helpful include:

• What were you arguing about?

This question minimises a serious situation. It is normal for couples to argue but it is not normal or OK to feel frightened, or to be compelled to have sex. Cheryl may hear this question as blaming her, with the implication that if she had not argued the incident would not have happened.
• I don’t think it is fair to talk about Bob like that. He didn’t do anything to you, did he?
• You need to leave him right now.

These responses miss the point that Cheryl may be describing a situation where she is frightened of her partner and may be describing rape in marriage. Criticising her husband or telling her to leave him may provoke Cheryl to defend her husband. Family violence is disempowering.3 Cheryl will benefit from support in gaining a clearer perspective and making her own decisions.

In studies assessing women’s views of encounters with clinicians, consistent themes have emerged about their expectations of how GPs should respond to issues of intimate partner violence.2 The main expectations are that GPs should have an understanding of the issue, be alert to signs of abuse and raise the issue in a supportive, compassionate and non-threatening way. A non-judgemental but confident approach, with assurances that confidentiality will be maintained, is essential.2

ANSWER 2

Domestic violence is not limited to physical abuse and can include emotional, sexual, economic and social abuse, and neglect.2 It can happen in any social group. The RACGP white book2 provides excellent information and guidance about this subject for the GP.

From Cheryl’s description of Bob’s behaviour towards her, it is clear that she has experienced physical abuse. His insistence on having sex when she did not want it is sexual abuse. The demeaning nature of their argument the night before her visit to you indicates that she may also be subjected to emotional abuse.

The Australian Bureau of Statistics Personal Safety 2012 survey4 found that 17% of women aged 18 years and over had experienced violence by a partner; 1.5% of women in a relationship had experienced physical violence in the previous 12 months and 25% had experienced emotional violence. The violence can continue over many years. In 20% of cases the violence commences during pregnancy. Family violence often continues for many years.

ANSWER 3

It is important to accurately document information that Cheryl gives you at this visit, including any health complaints and symptoms, as you would at any other visit. You could also record Cheryl’s descriptions of the events using quotation marks. You should document in detail your observations of Cheryl’s condition, behaviour and any injuries she may have, as well a history of how the injuries were sustained.2

This situation is directly relevant to Cheryl’s mental and physical health, and potentially her life and safety: it is important, therefore, to make detailed notes of the discussions.2

It is also important for Cheryl that there be a record of the alleged violence in case of any legal issues that may arise in the future. For example, Cheryl and Bob may need to separate and there may be family court orders about childcare or other legal disputes. It is invaluable for the patient to have a contemporaneous record.2

ANSWER 4

This is a difficult issue. Some practice software allows a patient’s notes to be restricted to one-doctor access. However, this would not meet Cheryl’s needs as she sees other doctors in the practice from time to time. One suggestion is to write a paper medical note and scan it into the record under a title such as ‘special note confidential between patient and doctor (insert your name)’ with the date. It is worth discussing this issue at a practice meeting and confirming the suitability of any innovative arrangements with your medical defence organisation.

ANSWER 5

Immediate concerns are assessing Cheryl’s risk and safety. This should be informed by your professional judgement of Cheryl’s situation, Cheryl’s assessment of her risk and safety, and the presence of risk indicators such as Bob’s history of violent behaviour, mental health problems, access to lethal weapons, and use of drugs and alcohol.2

You could ask the following questions to assess her safety:2

• Does Cheryl feel safe to go home? If not, you should help her to find somewhere safe where she can go. If yes, then help her to develop a safety plan (see below).2
• How safe does she feel?
• What does she need to feel safe?
• How safe is Kate?
• Is Bob obsessive about Cheryl?
• Is Bob controlling or abusive in other areas (eg financial, emotional, her relationships with friends and families, isolating her)?
• Is there a weapon in the house?
• Has Bob threatened Cheryl with a weapon?
• What does she mean by ‘I can’t go on like this’?
• What resources does Cheryl have to call for help or move to a place of safety (eg neighbours, family and money)?

Some women may be followed home from work or become trapped at home with the telephone disconnected and without access to money, car keys, Medicare and ATM cards or other basic means to leave. It is important to help Cheryl to consider her situation and, if necessary, to plan to be able to leave. An example of safety information for women is shown in Table 1.

Useful information to obtain from a further history could include:

• whether the violence is escalating now
• additional history about the choking, smothering or strangulation, which is a significant risk factor for future homicide and may often leave no visible marks or injuries5,6
• history of any past attempts to leave
• history of prior abuse in other relationships (childhood abuse is a risk factor for being a victim of abuse as an adult7,8).
Women's health

CASE 2

Medicare Local and/or practice can ensure that the list is kept up to date.

- The telephone service 1800RESPECT offers 24/7 phone counselling. The 1800RESPECT website has online counselling and information for victims, professionals, and friends and family.
- Local police or emergency services (000) should be contacted if Cheryl and/or Kate are in danger. In some states there are specialist police domestic violence liaison officers. The police can provide information on court orders to restrain or apprehend violent offenders. These orders can exclude a violent person from a home or another location but do not necessarily mean that the couple cannot continue to live together.
- In some states there are programs, such as Staying home leaving violence, where the victim and the children stay in their home. The perpetrator is mandated to leave the house and the locks are changed.

Any past history of violence or sexual abuse is relevant and should be addressed when Cheryl is ready. Domestic violence or counselling services can assist with this if and when Cheryl is ready to be referred to the appropriate health professional.

Cheryl may need to be very careful with any material she takes home as it may trigger further abuse if her husband finds it.

SUMMARY

The above discussion illustrates the following nine steps to intervention (the nine Rs), recommended by the RACGP white book:

1. Role with patients who are experiencing abuse and violence
2. Readiness to be open to
3. Recognise symptoms of abuse and violence, ask directly and sensitively and
4. Respond to disclosures of violence with empathic listening and explore
5. Risk and safety issues
6. Review the patient for follow-up and support
7. Refer appropriately and also
8. Reflect on our own attitudes and management of abuse and violence
9. Respect for our patients, our colleagues and ourselves is an overarching principle of this sensitive work.

CONCLUSION

Cheryl decides that she and Kate will stay with her sister for a couple of days so she can think about what she should do. She agrees to phone 1800RESPECT from her sister’s house today. She thanks you for your help. She tells you this is the most she has ever told anyone about the violence. You again acknowledge her bravery. You offer to continue to see her and make a follow-up appointment.

<table>
<thead>
<tr>
<th>Table 1. Safety planning9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Safety during an abusive incident</strong></td>
</tr>
<tr>
<td>• Be aware of all exit routes and safety spots</td>
</tr>
<tr>
<td>• Have a plan that includes how to:</td>
</tr>
<tr>
<td>– call emergency (000)</td>
</tr>
<tr>
<td>– safely exit the house</td>
</tr>
<tr>
<td>– seek help</td>
</tr>
<tr>
<td>• Ask neighbours to call the police if they hear any disturbance</td>
</tr>
</tbody>
</table>
REFERENCES


CASE 3
JACKIE FEARS SHE WAS RAPED

Jackie, aged 24 years, comes to see you late on Saturday morning, teary and distressed. She last saw you 9 months ago for a Pap smear. She is in good health. She tells you that she thinks she was drugged the night before and woke up with a man on top of her who was having sex with her. She is worried she may catch something.

QUESTION 1 🎧 🎧
What is the most strategic approach for managing this consultation?

QUESTION 2 🎧 🎧
What messages are therapeutic for someone disclosing rape?

QUESTION 3 🎧
What are some common emotional responses to rape?

QUESTION 4 🎧 🎧 🎧
As your time is limited on this occasion, what issues should be a priority at this stage?

QUESTION 5 🎧 🎧 🎧
What care and options are open to an adult who has been raped? What help is available to you to manage Jackie’s immediate needs?

FURTHER INFORMATION

Following discussion, Jackie provides a more detailed history. Jackie has been in a new job at an advertising agency for 2 weeks. On Friday night Jackie and her colleagues had a few drinks after work and then some colleagues invited her to go with them to a party. She felt a bit tipsy in the taxi. At the party, she had one more drink and then felt dizzy and unwell. She stumbled and a man helped her up the stairs and into a bedroom to lie down. She woke up with a man on top of her, having vaginal sex with her. She felt weak and sick and tried to tell him to go away and that she did not want to do this. He did not stop. After he left, she slowly recovered, found her clothes and got dressed. She phoned her sister who came and picked her up and brought her to your clinic this morning. You are concerned that this consultation should ideally take longer than you can manage on a busy Saturday.
FURTHER INFORMATION
The nearest sexual assault centre with a forensic facility is 3 hours drive away from your clinic. Jackie wants to talk about risks of STIs and then go home and rest before she does anything else. After further discussion, Jackie insists on going home and says she is not ready to talk to the police at this time.

QUESTION 6 📢
What will you do now? Would you prescribe anything?

FURTHER INFORMATION
Jackie attends your surgery about a year later on an unrelated issue. You have not seen her since some time ago when she told you she was attending counselling.

QUESTION 9 📢
Is it helpful to ask her how she is after the rape?

QUESTION 8 📢
Jackie wants to know how it is possible there was nothing in her system?

FURTHER INFORMATION
The nearest sexual assault centre with a forensic facility is 3 hours drive away from your clinic. Jackie wants to talk about risks of STIs and then go home and rest before she does anything else. After further discussion, Jackie insists on going home and says she is not ready to talk to the police at this time.

QUESTION 6 📢
What will you do now? Would you prescribe anything?

FURTHER INFORMATION
Jackie went to the police, who are investigating her case, and she had the forensic examination.
You see Jackie at 2 weeks and 3 months for her sexual health follow-up. She tells you that her flashbacks are subsiding, her sleep is improving and she is beginning to feel normal again. The police have laid charges against a man who was at the party. She is aware that recovery may be a long process and that her appearance in court could be traumatic, but she has decided to go ahead with it and has decided to continue with the support of her sexual assault counsellor.
At her visit today, she has a question to ask you. She has just heard from the police that her urine and blood tests did not show the presence of any drugs.
• Pregnancy prevention with postcoital contraception
• Assessing for injury (most people who are raped do not have injuries requiring treatment)
• Expressing support and affirmation for Jackie
• Her social safety:
  – Does she have somewhere safe to go and where she can be supported on leaving the surgery?
  – Will she be physically and emotionally safe at work?
  – What is her emotional/psychological situation (mental health risk assessment)?
• The legal/police situation (Jackie may have been drugged and raped).

Ideally, she should be referred today to a sexual assault service with a counsellor and doctor for psychosocial support, medical care, and, if she chooses, a forensic examination, which is best done as early as possible and within 72 hours.

**ANSWER 5**

The following care and legal options might be available to an adult who has been raped.

**Care**

This depends on where you practice. New South Wales, Victoria, Adelaide, Perth and other locations have specialised sexual assault services where a sexual assault counsellor and a specially trained doctor offer a coordinated psychosocial and medical response and a forensic medical examination if the patient chooses this. The counsellor will also support the patient during any legal process, if one is undertaken.

**Legal**

The patient can report the crime to the police for investigation and, where appropriate, for police assistance in promoting the patient’s safety (eg to facilitate a court order to prevent future violence or stalking). Police receive training in how to respond to victims of sexual assault and most members of the police force will respond in a sensitive and supportive manner. The police will investigate and, if they can gather sufficient evidence, press charges. This does not depend on whether the patient has physical injuries. In general terms, victims of rape retain control of whether the matter goes to court and in most cases they can withdraw from the police process at any time, up to when the case goes to court.

The police will request that Jackie has a forensic medical examination. This is performed by a forensically trained doctor or nurse, who takes a history, carefully and sensitively examines and documents any injury, and collects swabs from relevant areas to test for the offender’s DNA, as well as blood and urine for toxicology testing. The process will be carefully explained to Jackie and she would then have the option to decline any part of the examination (eg speculum use). In dedicated sexual assault centres, the counsellor and doctor work together to provide a holistic service.
It is very valuable to have a local list of services available in your practice, including 24/7 for sexual assault, family violence, etc. This could be prepared and kept up to date by each Medicare Local or by practice staff. You could refer Jackie to the:

- 24/7 telephone counselling service: Rape and Domestic Violence Services Australia (previously known as the Rape Crisis Centre), 1800RESPECT, www.rape-dvservices.org.au
- nearest hospital social worker or emergency department
- police.

Police websites also have useful information on sexual assault (refer to Resources for patients and doctors).

**ANSWER 6**

At this stage, the next steps must be tailored to the patient’s history, local STI risk and their likelihood of returning for adequate follow-up. The latest guidelines are available in the *National Management Guidelines for Sexually Transmissible Infections*. The RACGP white book and Yarrowplace Rape and Sexual Assault Service also provides some guidance. The Royal Prince Alfred (RPA) Sexual Assault Service provides the following protocol:

At presentation consider prophylaxis for:

- pregnancy prevention
  - levonorgestrel 1500 mg, taken as soon as possible or up to 120 hours later (as its risks are minimal)
- chlamydia, gonorrhoea and syphilis
  - azithromycin 1 g or follow local guidelines, especially if follow-up is not likely
- hepatitis B virus (HBV) infection
  - commence vaccination if not immunised
- human immunodeficiency virus (HIV) infection
  - assess whether post-exposure prophylaxis might be required.

It is important to advise the patient that at this stage it is too early to test for most STIs and that follow-up is essential to ensure that appropriate testing takes place.

At 2 weeks follow-up:

- check blood for HBV, hepatitis C virus (HCV), syphilis, HIV (timing of HIV testing may vary to 4 weeks, depending on the laboratory capability) and β-human chorionic gonadotropin (β-hCG)
- test for chlamydia/gonorrhoea by polymerase chain reaction (PCR) at potentially exposed sites.

At 3 months follow-up:

- check blood for HBV, HCV, HIV and syphilis.

In cases where there might be an increased risk of HCV transmission (eg infected needles used during the assault), a 6-month HCV test will be required.

As Jackie insists on going home, a suitable plan needs to be discussed with her. It is agreed that her sister will stay with her today. Jackie also agrees that they will telephone the rape crisis counsellor (1800RESPECT) when they go home for advice about her options for reporting to the police and for couselling and care.

**ANSWER 7**

The following information and advice could be provided to Jackie:

- Do not shower or wash.
- Place the clothes she was wearing in a bag (preferably in individual paper bags). Also advise Jackie to preserve any panty liners, tampons, etc, if relevant.
- If she needs to use the toilet she should press her panties into the vulva before urinating or opening the bowels. Jackie should save these panties in a bag.

There is no approved method of preserving any evidence of drugs that may have been given to her until she can have blood or urine collected. You could consider offering to take samples for your pathology service to screen and hold.

**ANSWER 8**

Several possibilities could account for the fact that no drugs were identified in her urine and blood samples. These include the following:

- Many drugs are eliminated very rapidly from the body.
- Some of the new designer drugs may not be detected at all with current testing methods.
- A common method for spiking of drinks is the use of ‘extra’ alcohol.
- It is possible for a person to lose track of how many alcoholic drinks they have had or not realise that the same number of drinks can have a variable response depending on other factors such as fatigue, other medications or drugs.

Discussion of the last point needs to be handled very sensitively, as victims of rape often tend to blame themselves and tend to very easily hear blame from others. The victim being intoxicated does not excuse the perpetrator of a crime, or mean that the victim is to blame. However, if history shows that Jackie does drink to a dangerous level, it may be helpful to discuss the many health risks of excessive alcohol consumption with Jackie.

**ANSWER 9**

It is helpful to ask how she is and give her an opportunity to talk if she wishes to do so. Research shows rape survivors find ‘a wall of silence’, where the opportunity to talk is limited or absent, and this does not promote recovery. You also do not want to give the impression that today or every time she sees you she is required to think or talk about the rape. It may be helpful to ask her if she wants to fill you in on how she is going, while reassuring her that it is not necessary to talk about it if she does not want to.

**CONCLUSION**

Jackie is glad you asked. She is proceeding with the police and court case despite the date of the court case being postponed twice due to legal delays. The counsellor is available on the telephone to support her in this. She is rarely having flashbacks but has occasional anxiety. She is still fearful of meeting the man and had considered moving...
check Women's health

interstate. She has decided to leave the advertising world and has commenced retraining as a nurse. She is grateful for your support to her and her sister on that busy Saturday morning and this has influenced her decision to consider a career in health.

REFERENCES

RESOURCES FOR PATIENTS AND DOCTORS
CASE 4
EMILY’S SECRET PAIN
Emily is an art teacher aged 30 years and has been in a relationship for 3 years with Jason, an engineer. She has a 2-year history of increasing pain with sex and with Pap smears. Emily and Jason have not had sex for the past 6 weeks, as Emily cannot bring herself to have sex any more. This situation has precipitated her appointment today.

QUESTION 1
What questions would you ask Emily to collect a relevant history?

QUESTION 2
Emily asks ‘What’s wrong with me?’ How would you respond?

QUESTION 3
Emily asks ‘Am I the only one? I’ve never heard of anyone else having this.’ How would you answer?

QUESTION 4
How would you discuss this with her and how would you proceed?

QUESTION 5
What are the options and rationales for the treatment of vaginismus?

QUESTION 6
What can doctors do to help identify and treat vaginismus?

FURTHER INFORMATION
On questioning, it transpires that Emily enjoyed her sexual relationship with Jason in the first 6 months, before they moved in together. However, since then there had been a number of stresses and Emily was scared that the relationship would be at risk if something did not change soon.

Vaginal examination and Pap smears used to be fine until her last Pap smear. On that occasion there was a different doctor and he needed to repeat the Pap smear because he did not get enough cells the first time. Emily felt quite tense because he seemed rushed but she said nothing, even though the procedure hurt her a lot. The doctor said that the Pap smear would be over soon and she knew it would be, but found the pain excruciating while it was being performed.
**ANSWER 1**

A psychosexual history helps us understand what life circumstances, including health issues, may have contributed to the patient’s symptom(s). Relevant questions for a psychosexual history include questions regarding Emily’s personal, medical, sexual and psychosocial history (Table 1).

**Table 1. Obtaining a psychosexual history**

<table>
<thead>
<tr>
<th>History</th>
<th>Possible questions/discussions points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal history</td>
<td>What was it like growing up in your family? Was sex talked about or was it unmentionable? Were parents physically affectionate? How did you find out about sex? What were your ideas about it before you got started? How did you find out about periods? Any pain with periods? Tampon use?</td>
</tr>
<tr>
<td>Medical and surgical history</td>
<td>Ask especially about history of pelvic surgery, infections (eg recurrent thrush), episiotomies, etc.</td>
</tr>
<tr>
<td>Relationship history</td>
<td>Relationships with previous partners. Feelings of self-worth and desirability. Relationship with current partner.</td>
</tr>
<tr>
<td>Sexual history</td>
<td>Contraception. Past-traumatic experiences: physical/sexual abuse, sexual assault or painful vaginal examination</td>
</tr>
<tr>
<td>Psychosexual history</td>
<td>Describe the problem in detail. Has the problem always been there? Has this been a problem in any previous relationship? The reason for coming now</td>
</tr>
</tbody>
</table>

**ANSWER 2**

On the basis of her presenting and psychological history, Emily has vaginismus. She has had severe pain with penetration until penetration felt impossible and with Pap smears.

Vaginismus is newly classified in the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5),* as part of a genitopelvic pain disorder/penetration disorder. The DSM-5 states that the most frequent clinical presentation is one in which both psychological and physiological factors contribute. Associated features are described as partner factors, relationship factors, individual vulnerability factors, cultural or religious factors, as well as medical factors.

There has been a fundamental shift over the past two decades from a dualistic view of the aetiology of painful and/or difficult vaginal penetration as being due to either psychological or physiological causes to the current multifactorial perspective, with a biopsychosocial lens, which sees a complex interplay between physiological, psychological and social factors.

Women with vaginismus often avoid sexual intercourse, experience involuntary muscle contraction and anticipate, fear or experience pain or burning with penetration. The degree of distress is more central to the diagnosis than muscle tone.

**ANSWER 3**

Women feel isolated and ashamed when penetrative sex is painful or impossible. Although the population prevalence of vaginismus remains unknown, it has been reported to be 5–17% in clinical settings. It might also be helpful to explain that vaginismus may be primary (ie pain at first intercourse) or secondary (ie developing after pain-free intercourse, as in Emily’s case following a painful Pap smear).

**ANSWER 4**

It is important to conduct an examination to diagnose organic pathology, but the psychosexual examination, like a Pap smear, is not urgent and can wait until Emily feels ready. She needs to know that she can speak up if she is uncomfortable and trust that her doctor will listen to her and respect her wishes. Avoidance of Pap smears or pain with Pap smears can be indicators of past trauma. Given that the biggest risk factor for cervical cancer is not being screened regularly, it is important to ask women if they have had their routine health checks and if not, why not. Ensuring that women get the help they need to deal with painful or stressful feelings that have resulted in pain or ‘tight muscles’ will enable them to have normal preventive healthcare when they feel ready.

Several visits may be required before a woman is ready to be examined and any examination should be approached gently. For example, when she is ready to be examined, you could ask Emily to tell you if there is any pain or discomfort, or if she wants to stop the examination at any time. You should be watching for any signs of distress, but you should avoid inadvertently causing pain (iatrogenic pain). Describe in detail everything that you intend to do. Inviting her to contract then relax her pelvic muscles or instructing her to take a deep breath in then exhale slowly, are two physical ways to help her vaginal muscles relax and allow a finger to slide in.

The clinical examination can be used as a learning tool to educate patients on performing self-examinations at home. As Emily familiarises herself with this hidden part of her body in the privacy of her home, fantasies or fears that she has with penetration may emerge that can be discussed as part of her therapy. This helps connect the physical (how it feels) and emotional (what it’s like for her) when talking about painful feelings in her body and her life.

**ANSWER 5**

Some doctors and patients, think that if penetrative sex and pelvic examination were possible (ie symptoms were ‘fixed’) the patient’s problems would be solved; hence the offer of surgery, ‘stretching’ under anaesthesia, dilators, biofeedback, oral and intravaginal anxiolytics, botox injections, lignocaine gel and nitroglycerin
The rationale for these treatments is that the problem is ‘spastic’ vaginal muscles. There is very limited evidence from controlled trials concerning their effectiveness.7

The ethics of prescribing medication or performing surgery, which have potential side effects on patients whose problems are not organically based, has not received much attention. This is because of the value placed on ‘normality’.8

Often, doctors and patients believe that ‘getting a Pap smear over quickly’ will shorten the duration of pain for a frightened patient and therefore be helpful. However, this can inadvertently re-traumatise a patient who has a history of physical/sexual abuse or sexual assault (iatrogenic traumatic examination).9–11

The DSM-5 consensus that vaginismus has biopsychosocial origins2 suggests that we should treat the patient holistically, not just treat the symptom. Psychosexual therapy is the only therapy to adopt a biopsychosocial model of diagnosis and treatment. In this model, vaginismus is conceptualised as a psychosomatic symptom: the symptom is the result of a complex interplay between physiological, psychological and interpersonal factors, expressed in the body (soma) as a painful symptom, which alerts us to painful feelings. An integrated approach to management is offered on the basis of this understanding. The aim of treatment is not to achieve tolerance of penetration but to encourage participation in sex only when it is pleasurable and pain-free. Individual and relationship issues are important, as is the experience of sex for the patient.12

Elements of treatment

The psychosexual history and examination (when the patient is ready) gives the doctor information needed for understanding the patient’s problem in the context of her life and diagnoses any physical causes that need treatment (Tables 2, 3). It also begins the process of treatment where the woman, with or without her partner, can begin to make connections between what has happened in her life and how she has been affected by it. It requires a factual, non-judgemental attitude by the doctor.

Table 2. Physical/medical causes of pain that may be contributory factors in vaginismus4,5

<table>
<thead>
<tr>
<th>Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurrent genital tract infections (e.g. thrush) and topical treatments</td>
</tr>
<tr>
<td>Vulvovestibulitis</td>
</tr>
<tr>
<td>Oestrogen deficiency (peri/post-menopause, following oophorectomy (surgical menopause)</td>
</tr>
<tr>
<td>Prolonged use of depot medroxyprogesterone contraception</td>
</tr>
<tr>
<td>Trauma associated with childbirth (including episiotomy)</td>
</tr>
<tr>
<td>Genital surgery, radiotherapy and irritation caused by douches, spermcides or latex in condoms</td>
</tr>
<tr>
<td>Diabetes, multiple sclerosis or spinal cord injury (patients may experience pain with penetration because of poor lubrication)</td>
</tr>
</tbody>
</table>

There is controversy around the differentiation between vulvar vestibulitis syndrome (VVS) and vaginismus because patients with vaginismus may also show signs of allodynia on the cotton bud test.

Table 3. Understanding and addressing features of vaginismus

<table>
<thead>
<tr>
<th>Feature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Many women are unfamiliar with this hidden part of their body (i.e. the vagina)</td>
</tr>
<tr>
<td>There may be an associated fantasy that the vagina is too 'big enough' for the adult world of sex</td>
</tr>
<tr>
<td>Their bodies harbour painful feelings (physical and psychological)</td>
</tr>
<tr>
<td>The unresolved issues that lead to pain and tightness may be unconscious. Patients are fearful and the symptom is self-protective. Some may feel disgust13 with the sexual part of their body</td>
</tr>
<tr>
<td>Address pain and tightness in vaginal muscles (specialist psychotherapy) and address painful feelings (psychosexual therapy)</td>
</tr>
<tr>
<td>The patient needs to feel in control and they need to develop trust, slowly and gently</td>
</tr>
</tbody>
</table>

Patients should be encouraged to talk about their feelings, and their fears, genital pain, pelvic floor muscle tension and issues of sexual pleasure5,14 Treatment should be individualised for each woman, with or without her partner.

Encouraging non-penetrative sex is important at times when penetrative sex would interfere with progress of treatment. Specially trained physiotherapists with skills in patient education (anatomy, physiology of sexual response) and gentle examination are helpful in a multidisciplinary approach. Initially, the woman is encouraged to look at and self-touch in a nonsexual manner, moving on to the insertion of a finger, then a small tampon. This can be combined with pelvic floor physiotherapy. Whilst the use of dilators has been a standard approach for physiotherapist-led treatment, this focus on tolerating increasingly sized dilators can make self-examination at home feel more like stretching exercises than exploration to see how the vagina and the examining finger feel, what that’s like for the woman, and what feelings are aroused, increasing her sense of mastery of her own body as she gets in touch with her feelings around sex.

Recommendations on sexual activity

Women often feel guilty and men may feel frustrated by the idea of non-penetrative sex for a period of time. However, with penetrative sex being off the agenda, there may be more experimentation with non-penetrative sex (foreplay). This may lead to an increase in trust, arousal and natural lubrication, and improvement in sexual connection, especially when penetrative sex has been the primary mode of sexual expression. It will also help differentiate between patients for whom penetrative sex is the primary problem (individual issues) and those for whom there are additional relationship difficulties to be addressed, as the latter patients tend to continue to avoid sex.
ANSWER 6

Many women who have sexual pain do not discuss their problems with health providers. A Swedish study reported that only 28% of approximately 3000 women aged 20–60 years consulted their doctor regarding prolonged and severe dyspareunia.15

Doctors can take a leading role in identifying vaginismus and ensuring that patients have regular Pap smears by making Pap smears a positive experience for their patients (Table 4), as well as offering education, counselling and other support as required.4

Table 4. What can doctors do?

| • Ask all female patients if they have had routine Pap smears |
| • Refer patients who have pain with sex or Pap smears for psychosexual therapy with or without pelvic floor physiotherapy |
| • Ensure there is no pain with Pap smears; Pap smears should be done when the patient feels ready, under her direction |
| • Ensure that patients understand that they can stop an examination at any time, as many patients have difficulty saying ‘no’ |

CONCLUSION

Jason accompanied Emily to her second appointment. At this visit, information and education on vaginismus were provided. The problem was discussed, as well as how it affected each of them. The importance of a period of non-penetrative sex until Emily was ready was also discussed. Jason said it would be hard for him, as they were already doing the ‘no sex’ thing and they had not had sex for at least 6 weeks. It was explained that non-penetrative sex did not mean ‘no sex’ and that their sex life was important. Other forms of sexual activity could continue as long as Emily felt comfortable. Emily confirmed that she had been avoiding anything more than a hug because of her fear that it would lead to attempts at penetrative sex. She knew it wasn’t good for their relationship but she didn’t know what else to do.

Emily thought it would be helpful for them to continue to attend sessions together to deal with tensions that had built up in the relationship. She was pleased to be referred to a specialist physiotherapist to help at the physical level. After 6 sessions together, Emily came by herself to sort out her feelings about her body and sexuality. She now trusted Jason to go no further than she was comfortable with. Both were finding their (non-penetrative) sexual relationship rewarding. Within 6 months Emily felt ready to guide Jason’s finger into her vagina in a way where she felt in control. She was then ready to guide him towards penetrative sex, happy to feel that this was something she wanted and felt ready for, and confident that she could say ‘no’ if she didn’t want to participate for whatever reason.

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8. Moynihan R, Cassels A. Selling sickness: how the world’s biggest pharmaceutical companies are turning us all into patients. Sydney: Allen & Unwin, 2005.

RESOURCES FOR PATIENTS


RESOURCES FOR DOCTORS

CASE 5

JESSICA HAS HAD NO PERIODS FOR 4 MONTHS

Jessica is a beautician aged 26 years. She is concerned about oligomenorrhoea, which she has had for the last 4 months. She is not taking any medications. Jessica had menarche at the age of 14 years and her cycles have always been irregular (45–60 days). She is currently sexually active and her partner uses condoms for contraception. They do not have any plans for pregnancy. There is a strong family history of type 2 diabetes (T2DM) and myocardial infarction on Jessica’s father’s side. Jessica has gained 7 kg over the past 2 years, which she is struggling to lose. She has a sedentary lifestyle as she works full time and has little time for exercise.

On examination she is not cushingoid. She is normotensive and has a body mass index (BMI) of 28 kg/m² (weight: 79 kg, height: 168 cm) and central adiposity with a waist circumference of 89 cm. On further questioning, Jessica describes excessive facial hair growth, which requires regular waxing. She gives herself a score of 11 on the Ferriman-Gallway (FG) scoring system for hirsutism.¹

CASE 5

QUESTION 1

What are the key issues in Jessica’s history?

QUESTION 2

What is the most likely diagnosis? What investigations would you perform to confirm the diagnosis?

QUESTION 3

What is the diagnosis?

QUESTION 4

What are the key health challenges for Jessica? What general approach should you take to manage her key issues?

QUESTION 5

What therapeutic options for oligomenorrhoea should be considered and discussed with Jessica?
QUESTION 6 🔄
What role would weight management have in improving Jessica’s metabolic and reproductive features and how will you facilitate this?

FURTHER INFORMATION
Jessica’s oral glucose tolerance test (OGTT) shows normal results and her fasting lipids show mild dyslipidaemia with normal total cholesterol and low-density lipoprotein-cholesterol (LDL-C) levels, and a low level of high-density lipoprotein cholesterol (HDL-C). Jessica chooses to start a COC for regulation of her periods and considers laser therapy for hirsutism. She starts seeing a dietician, as well as attending regular aerobic exercise sessions at the local gym to achieve weight loss.

Four years later, Jessica visits you, after presenting to the emergency department the day before for vaginal bleeding and abdominal pain. She was found to be pregnant and was referred for an ultrasound, which confirmed a live pregnancy at 8 weeks of gestation. The bleeding stopped and Jessica was reassured that the pregnancy was still viable at this stage.

On examination, her weight is 73 kg, BMI is 26 kg/m² and she is normotensive. Jessica tells you that she stopped taking her COC about 6 months ago with the aim of getting pregnant. Knowing her previous history of PCOS, you referred Jessica for an early OGTT to screen for gestational diabetes. Her fasting plasma glucose was 5.1 mmol/L and 2-hour plasma glucose was 9 mmol/L.

QUESTION 7 🔄
How would you interpret this result? What would be your approach?

QUESTION 8 🔄
What information would you give Jessica regarding postpartum screening for diabetes?

QUESTION 9 🔄
How would you advise Jessica about her risk of T2DM? How should this be managed?

QUESTION 10 🔄
What is the risk of gestational diabetes mellitus (GDM) with Jessica’s future pregnancies? What would you advise her about pre-pregnancy screening for dysglycaemia in women with PCOS?
Diagnosis of PCOS requires two of the three Rotterdam criteria, which are the internationally accepted diagnostic criteria for PCOS, as well as exclusion of other aetiologies, such as hypothyroidism, Cushing’s syndrome, late-onset congenital adrenal hyperplasia (CAH), androgen-secreting tumours and hyperprolactinemia. The Rotterdam criteria are:

- oligo- or anovulation
- clinical and/or biochemical signs of hyperandrogenism
- polycystic ovaries on ultrasound.

Recommended investigations to confirm the diagnosis include:

- Measurement of testosterone, SHBG and free androgen index (FAI) or calculated free testosterone. Total testosterone alone or additional androgens, including androstenedione and dehydroepiandrosterone sulphate, are not recommended in routine investigation of PCOS.

- A pelvic ultrasound could be performed to assess ovarian morphology, if required for diagnosis, and should be performed in the follicular phase of the menstrual cycle where possible. Pelvic ultrasound is also useful for measurement of endometrial thickness in the setting of oligo-/amenorrhea. However, it is not required in all cases (it should be performed per vaginal and by an experienced gynaecological ultrasonographer to increase accuracy where possible), and is not recommended in adolescents, especially if they are not yet sexually active; 60–80% of adolescents will meet PCOS criteria as they reach reproductive maturity.

- Measurement of TSH, serum prolactin, 17(OH)-progesterone (in the follicular phase to exclude CAH) and β-hCG should be undertaken to exclude other causes.

It is difficult to assess androgen status in women who are on the combined oral contraceptive (COC) pill as its effects include oestrogen-mediated increases in SHBG and reduction in androgens; therefore, COCs should be withdrawn, ideally for 3 months prior to reliable hormonal investigation.

Referral to an endocrinologist is necessary for work-up if other rare causes, including Cushing’s syndrome, non-classical CAH or rare androgen-secreting tumours, are suspected clinically (ie rapidity and severity of onset, hypertension, virilisation, markedly elevated androgen levels or cushingoid features).

ANSWER 3

On the basis of irregular menses, clinical and biochemical hyperandrogenism and follicles on pelvic ultrasound, Jessica has PCOS. Note that other causes were excluded on the basis of biochemistry and the absence of clinical suspicion of more severe conditions.

ANSWER 4

Women with PCOS may present with a range of features, including reproductive (hyperandrogenism, hirsutism, anovulation, infertility), metabolic (insulin resistance, impaired glucose tolerance, GDM, T2DM, dyslipidaemia, obstructive sleep apnoea) and psychological (increased anxiety, depression and worsened quality of life) features. Women with PCOS are at a higher risk of developing...
pre-diabetes, GDM and T2DM, and have higher cardiovascular risk factors, all with onset at an earlier age and all affecting lean as well as overweight women. It is increasingly recognised that PCOS is not only a reproductive issue, but also a metabolic disease that carries important health risks from a young age.

A multidisciplinary approach including evaluation, patient education and consideration of treatment for each of the reproductive, metabolic and psychosocial areas is necessary. Targeted treatment options are summarised in Table 1.

Table 1. Targeted treatment options for polycystic ovary syndrome

<table>
<thead>
<tr>
<th>Oligomenorrhoea/amenorrhoea</th>
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<tbody>
<tr>
<td>• Lifestyle change (5–10% weight loss + structured exercise)</td>
</tr>
<tr>
<td>• Combined oral contraceptive pill (low oestrogen doses, eg 20 µg may have less impact on insulin resistance)</td>
</tr>
<tr>
<td>• Cyclic progestins (eg 10 mg medroxyprogesterone acetate 10–14 days every 2–3 months)</td>
</tr>
<tr>
<td>• Metformin (improves ovulation and menstrual cyclicity)</td>
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<table>
<thead>
<tr>
<th>Hirsutism</th>
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<tbody>
<tr>
<td>• Self-administered and professional cosmetic therapy is first line (laser is recommended)</td>
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</table>

<table>
<thead>
<tr>
<th>Pharmacological therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Consider if there is patient concern or if cosmetic treatment is ineffective/inaccessible/unaffordable</td>
</tr>
<tr>
<td>• Should be trialled for at least 6 months before making changes in dose or medication</td>
</tr>
<tr>
<td>• Primary therapy is the COCP (monitor glucose tolerance in those at risk of diabetes)</td>
</tr>
<tr>
<td>• Anti-androgen monotherapy (eg spironolactone) should not be used without adequate contraception</td>
</tr>
<tr>
<td>• Combination therapy – if 3–6 months of COCP is ineffective, add anti-androgen to COCP (daily spironolactone, and if &gt;50 mg twice daily)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Infertility</th>
</tr>
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<tbody>
<tr>
<td>• Advise smoking cessation, optimal weight, exercise and folate supplementation</td>
</tr>
<tr>
<td>• Advise regarding the age-related decline in fertility to allow optimal timing of family planning</td>
</tr>
<tr>
<td>• Infertility therapies may include clomiphene, metformin, gonadotropins, aromatase inhibitors, surgery and in vitro fertilisation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardiometabolic risk</th>
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<tbody>
<tr>
<td>• Lifestyle change with a &gt;5% weight loss in those who are overweight reduces diabetes risk by ~50–60% in high risk groups</td>
</tr>
<tr>
<td>• Metformin reduces the risk of diabetes by ~50% in adherent high risk groups*</td>
</tr>
</tbody>
</table>

*Lifestyle intervention is recognised as the first step in management of women with PCOS. A single or combined approach of diet, exercise and/or behavioural interventions is required. Weight loss (in women with a BMI ≥25 kg/m² [overweight/obese]) and prevention of weight gain (in women with a BMI 18.5–24.9 kg/m² [lean]) should be actively encouraged lifelong, as there is documented evidence that women who are insulin-resistant gain weight at a faster rate than unaffected women. Prevention of weight gain through regular monitoring, lifestyle efforts and support should be encouraged in all women with PCOS and requires far less lifestyle modification than weight loss.

For women who are overweight, a 5–10% loss of current body weight is an achievable realistic goal to set in the short term and has significant benefits across metabolic and reproductive features including pregnancy. Weight loss can be achieved through moderate reduction of energy intake, and introduction of moderate physical activity including structured exercise of at least 150 minutes per week with 90 minutes of this exercise being aerobic activity at moderate-to-high intensity. A large randomised controlled trial reported weight reductions of 5–10% over 2 years for a range of energy-reduced diets with different macronutrient content. It seems that caloric (energy) restriction per se, rather than macronutrient composition, is effective for weight loss and clinical benefits. Physical activity, even in the absence of weight loss, improves a range of factors including hypertension, insulin resistance, impaired glucose tolerance and ovulatory function, and should be encouraged in women with PCOS.

Management of reproductive features

Initial steps in management include planning early for family initiation, prevention of weight gain and intensive lifestyle programs, all of which are important in the management of PCOS in primary care. COCs are effective in achieving menstrual cycle regularity, providing contraception and controlling hirsutism; however, there may be a negative influence on insulin resistance, and a low-dose COC may be preferred. Fertility is not necessarily impaired in all patients with PCOS and, depending on the severity of their condition, some women conceive without medical intervention. Contraception, therefore, is still relevant. Smoking history, age, weight, metabolic risk and thromboembolism need to be considered when prescribing COCs.

If infertility is an issue, pharmacological options include ovulation induction with clomiphene citrate, metformin, gonadotropins and, more recently, aromatase inhibitors. Additional options include surgery (laparoscopic ovarian drilling) and, if ovulation induction is unsuccessful or there are other infertility factors, in vitro fertilisation. Steps to optimise fertility, including lifestyle changes, can be undertaken at the primary care level; however, once infertility (12 months of failure to conceive) is established, referral to a fertility specialist is recommended. In older women referral should not be delayed if infertility is suspected. Additionally, patients should be advised that a history of PCOS increases the risk for GDM, necessitating earlier screening during pregnancy.

When managing hirsutism the choice of therapeutic agents depends on patient preference, impact on wellbeing, access and affordability, and includes first-line cosmetic therapy (laser and electrolysis) and medical options (eg COCs with potential addition of an anti-androgen in generalised hirsutism if required).

Women with PCOS are at increased risk of developing endometrial...
cancer due to anovulation with unopposed uterine exposure to oestrogen. In this setting, intermittent progesterin every 3 months may be used to induce a withdrawal bleed and protect the endometrium from hyperplasia if the COC is not desired or tolerated.2,12

Management of metabolic features

National and international guidelines recommend the following screening program for metabolic risk management in PCOS:2,12

- Screen for pre-diabetes (impaired fasting glucose and impaired glucose tolerance) and diabetes
  - Start screening from a young age, especially preconception and early in pregnancy.*
- Encourage smoking cessation.
- Monitor anthropometric factors including weight, BMI and waist circumference at most visits.
- Measure fasting lipids every 2 years if normal and every year if abnormal and/or the patient is overweight or obese. The most common abnormalities are low levels of high-density lipoprotein cholesterol (HDL-C) and high levels of triglycerides.
- Measure blood pressure annually if BMI is <25 kg/m², or at every visit if BMI is >25 kg/m².

*An OGTT test is recommended every 2 years in all women and every year in those with additional risks for diabetes (age, ethnicity, parental history of diabetes, history of high glucose levels, smoking and use of COCs or antihypertensive medications, physical inactivity and waist circumference >80 cm). Note, even lean and younger women often have impaired glucose tolerance, providing opportunities for prevention; this is missed in 60–80% of cases with fasting glucose alone in this population.

Management of psychosocial features

Anxiety and depression are far more common in patients with PCOS, as is poorer quality of life. Mood disorders warrant screening and need to be addressed if present, to optimise engagement and adherence to lifestyle interventions. The national guideline recommends emotional health screening, especially for depression and anxiety, and provides an evidence-based, simple screening tool to facilitate this in women with PCOS.2

Therapeutic benefits of metformin in PCOS

Metformin is not first-line treatment in PCOS and its role in PCOS remains controversial.2 Nevertheless, large diabetes prevention trials that included women with PCOS have shown that metformin can prevent weight gain, but it is not a substitute for lifestyle interventions, nor will it further reduce weight in patients using effective lifestyle programs.13,14 Hence, metformin may remain a treatment consideration for prevention of weight gain, and management and prevention of impaired glucose tolerance and diabetes in women with PCOS, if diet and exercise are ineffective.4,12

Metformin also has a role in regulation of menses and ovulation, especially where contraception is not desired, as it has been shown to improve menstrual regularity and ovulation rate.12,15,16 Studies on metformin have not been sufficiently powered to study its effect on acne and hirsutism; some studies show benefit, but it is likely to be less effective than the COC.4

ANSWER 5

A stepwise approach to Jessica’s health issues is summarised in Table 2. Note that lifestyle intervention is always the core part of management.

ANSWER 6

Obesity exacerbates severity of PCOS.18 It is important, therefore, to explain to Jessica that moderate weight loss of 5–10% will result in:

- improvement of menstrual regularity, improved ovulation and

Table 2. A stepwise approach to Jessica’s health issues

<table>
<thead>
<tr>
<th>Reproductive features</th>
<th>Metabolic features</th>
<th>Psychosocial features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irregular menstruation</td>
<td>Obesity and cardiovascular risk factors</td>
<td>Screen for current features of depression or anxiety</td>
</tr>
<tr>
<td>Low dose COC or cyclic progesterone to induce withdrawal bleed (2–3 monthly)</td>
<td>Aim for weight loss of 5–10% of current body weight</td>
<td></td>
</tr>
<tr>
<td>Discuss potential risk for infertility and emphasise prevention of weight gain and weight loss 5–10% goal and confirm the value of early family initiation</td>
<td>Refer to a dietician</td>
<td></td>
</tr>
<tr>
<td>Metformin could be a potential option for restoration of menstrual regularity, and ovulation particularly if contraception is not desired or if she fails to lose weight with lifestyle interventions (start metformin at 500 mg of slow release daily to enhance GI tolerance and maximise the dose in weeks to months to reach 2 g/day)</td>
<td>Encourage regular exercise</td>
<td></td>
</tr>
<tr>
<td>Hirsutism</td>
<td>Regularly test markers of glucose metabolism, and cardiovascular risk (generally 2 yearly) including:</td>
<td></td>
</tr>
<tr>
<td>Laser therapy was discussed given the concern it caused for Jessica. Other options including the COC pill were also discussed.</td>
<td>• 75 g OGTT</td>
<td></td>
</tr>
<tr>
<td>• Fasting lipids</td>
<td>Discuss importance of preconception screening for diabetes, and early antenatal screening for gestational diabetes</td>
<td></td>
</tr>
</tbody>
</table>
reduced pregnancy complications\textsuperscript{19} 
• risk reduction for development of impaired glucose tolerance and T2DM\textsuperscript{10} 
• improvement in cardiovascular risk factors including dyslipidaemia and hypertension\textsuperscript{2} 
• improvement in psychological health.\textsuperscript{2}

\textbf{ANSWER 7}

GDM is defined as glucose intolerance of variable severity with onset or first recognition during pregnancy.\textsuperscript{11} It can be associated with increased risk of adverse pregnancy outcomes affecting both mother and fetus. History of PCOS is among the risk factors that necessitate early screening for GDM.\textsuperscript{11} A diagnosis of GDM is made if one or more of the following is present: \textsuperscript{11, 20}

• Fasting glucose ≥5.1 mmol/L
• 1-hour glucose ≥10.0 mmol/L
• 2-hour glucose ≥8.5 mmol/L.

Given her screening results, Jessica is diagnosed with early GDM.

\textbf{Management}\textsuperscript{20}

Referral to an antenatal centre where multidisciplinary care is provided, including access to a dietician, diabetes educator and an endocrinologist, is recommended. The initial step is patient education on how to self-monitor pre- and postprandial blood glucose levels. Initial treatment should consist of lifestyle interventions including nutrition therapy and moderate daily exercise for 30 minutes or more. Pharmacological therapy is recommended for women in whom lifestyle therapy is ineffective.

Regular weight monitoring and recommendations for healthy weight gain in pregnancy should also be discussed with Jessica. According to the 2009 Institute of Medicine recommendations, the total recommended weight gain for Jessica’s BMI of 26 kg/m\textsuperscript{2} is 7–11 kg.\textsuperscript{21}

\textbf{ANSWER 8}

Any blood glucose-lowering therapy being used during pregnancy will be stopped after delivery in women with GDM, unless overt diabetes is suspected. Women are screened for diabetes again at 6–12 weeks after delivery.\textsuperscript{20} Jessica will have her blood glucose measured by midwives for the first 48–72 hours after birth to exclude ongoing hyperglycaemia, and thereafter her follow-up will be as explained above. Given that Jessica was diagnosed early in her pregnancy, before conventional pregnancy-related insulin resistance occurs, it is highly likely she will remain with impaired glucose intolerance postpartum and she will have a high risk of early progression to T2DM.

\textbf{ANSWER 9}

Women with a previous history of GDM are at higher risk of developing diabetes in the future. Approximately 50% of these women develop diabetes within 10–20 years.\textsuperscript{22} Such women, therefore, require lifelong screening for the development of diabetes or pre-diabetes. Prevention of excess gestational weight gain and postpartum weight retention via lifestyle changes including healthy eating, regular exercise and maintaining a healthy weight is the key component to lowering this risk in the future.

As development of GDM is considered an additional risk factor to PCOS for development of diabetes, Jessica is considered to be at a higher risk and will require annual screening with OGTT.\textsuperscript{2}

\textbf{ANSWER 10}

There is 2–3-fold increase in the risk of GDM in women PCOS\textsuperscript{7} and, therefore, assessment of BMI, blood pressure and an OGTT prior to conception is recommended in these women.\textsuperscript{12} If no evidence of glycaemic abnormalities prior to conception, women with PCOS should undergo early screening for GDM with an OGTT at their first antenatal visit and this needs to be repeated at 24–28 weeks gestation if normal in early pregnancy.\textsuperscript{11}

There is also approximately a 30% chance of a recurrent GDM in a subsequent pregnancy in women with a history of previous GDM.\textsuperscript{23} Given the combined increase in risk, Jessica should be advised that planning of future pregnancies is essential. Screening with 75 g OGTT preconception should be discussed with her. Contraception should be encouraged to avoid unplanned pregnancy and, in Jessica’s case, the history of GDM should not affect the choice of contraceptive method.\textsuperscript{20}

\textbf{REFERENCES}


RESOURCES FOR PATIENTS AND DOCTORS

- The Jean Hailes Foundation, www.jeanhailes.org.au
QUESTION 2

Jane, now 41 years, comes to see you with 5-week-old James. Her husband travels extensively for work and is unable to provide much support. She has been mainly on her own for the past 3 weeks. A teary Jane tells you that she feels flat, irritable, tired and is not sleeping well. She says she cannot cope with two children on her own. She thinks she may have postnatal depression again. Which statement is the most correct?

A. Given her prior history of postnatal depression, Jane should be prescribed an SSRI immediately.
B. A score of 10 or more for Jane using the Edinburgh Postnatal Depression Scale (EPDS) suggests possible depression.
C. Jane has no risk factors for depression in her history.
D. Non-medication strategies are not appropriate for Jane given her history and symptoms.
E. Jane should be referred immediately to a perinatal psychiatrist.

CASE 2 – PENNY

Penny, a university student aged 20 years, has come to see you. She is dating a postgraduate student. When they try to have penetrative sex she feels extreme pain. They have never managed to have ‘full sex’ while dating. She had the same problem with her first ‘real’ boyfriend, leading to the break up of the relationship. She likes her current boyfriend and does not want to lose him.

QUESTION 3

Which of the following statements is correct with regard to obtaining a history from Penny?

A. You can assume that Penny has had two relationships.
B. Given her age, asking Penny questions about her medical and surgical history is not relevant.
C. Asking Penny questions about her family’s attitudes and beliefs towards sex may provide useful information regarding contributing factors to her current problem.
D. Asking Penny whether her parent’s relationship was physically affectionate is not useful.
E. Past traumatic experiences are unlikely to have contributed to Penny’s current problem.

QUESTION 4

Regarding Penny’s situation, which of the following statements is the most correct?

A. Given her history, Penny probably has secondary vaginismus.
C. Precise details of the population prevalence of vaginismus are unknown, but studies suggest a prevalence of 0.5–1.7%.
D. Penny should be referred for management of her ‘spastic vaginal muscles’, which may require surgery for stretching under anaesthesia.
E. Management of vaginismus involves treating the patient holistically with the treatment being individualised and patient-focused.

**CASE 3 – LUCIA**

Lucia, a university student aged 19 years, presents to discuss her infrequent periods, weight gain and increasing facial and body hair. Her periods, which have always been irregular, are becoming more infrequent. She has had four periods last year and none so far this year. She has never been sexually active. She has a strong family history of type 2 diabetes and cardiovascular disease. Her blood pressure is normal, her body mass index is 30 kg/m$^2$ and she has central adiposity with a waist circumference of 91 cm. She has mild hirsutism and otherwise looks normal.

**QUESTION 5**

Which statement describes the most likely diagnosis for Lucia?

A. Polycystic ovary syndrome (PCOS)
B. Hypothyroidism
C. Cushing syndrome
D. Late-onset congenital adrenal hyperplasia
E. Androgen-secreting tumour

**QUESTION 6**

Which one of the following statements is the most correct regarding management options for women with PCOS?

A. A multidisciplinary management approach is recommended.
B. Management of psychosocial features is the key priority.
C. Management of reproductive features is the key priority.
D. Management of metabolic features is the key priority.
E. Management priorities should be based on the patient’s key concerns.

**CASE 4 – EMILY**

Emily, aged 26 years, presents in a distressed state. She attended a party in a city apartment last night and got a bit drunk. She met a man she liked, who suggested they go into a bedroom to talk. She recalls kissing the man but when he began to undress her she said she was not interested in sex. He ignored her wishes, became forceful and angry, tore her clothes off and had sexual intercourse with her. He then left the apartment. She was in tears and called her mother. They came to see you right away.

**QUESTION 7**

Which statement below most correctly outlines appropriate next steps you should take following Emily’s disclosure of rape?

A. Careful consideration should be given to the initial words offered to Emily as these words may have a significant impact on her.
B. You should obtain a fuller history by gently asking her questions to further assess the situation.
C. Offer support and empathy.
D. You could refer Emily to the nearest sexual assault centre with a forensic facility.
E. All of the above.
QUESTION 10
In assessing Sally’s situation and formulating a plan to help her, which one of the statements below summarises the best action plan?

A. Report the incident to the police.
B. You should obtain additional history and ask Sally what she would like to do and provide her with resources to help her (details of local shelters and counselling services etc).
C. Assume that Sally is safe.
D. Break doctor–patient confidentiality by contacting Sam, whom you also see, to discuss the situation.
E. None of the above.
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*Eligibility criteria applies.