College of Human Medicine
MICHIGAN STATE UNIVERSITY

GYNECOLOGIC
CASE WRITE-UP EVALUATION FORM

For assignment details, see section of OB/GYN clerkship handbook entitled *Obstetric and Gynecologic Case Write-Up.*

ITEMS BELOW ARE COMPLETED BY THE STUDENT AND SUBMITTED AT THE SAME TIME AS THE H&P BY THE DEADLINE.

STUDENT NAME:_____ DATE SUBMITTED:_____

DISCUSSION TOPIC: Heavy Menstrual Bleeding WRITE-UP #1, #2, or RE-WRITE:_____

ITEMS BELOW ARE COMPLETED BY THE INSTRUCTOR.

TIMELY SUBMISSION? ✓ LEGIBLE? ✓ TURNITIN (≤ 15%):

H&P COMPONENTS

1. Chief Complaint
   - ☑ Limited to a symptom(s) or sign(s); or what the patient stated in quotations?
2. History of Present Illness
   - ☑ Complete?
   - ☑ Adheres to chronology?
   - ☐ Clearly written/concise?
   - ☑ Contains pertinent ROS if indicated?
3. Past Gyn History
   - ☑ Includes menstrual history?
   - ☑ Includes history of STIs?
4. Past OB History
   - ☑ Includes total number of pregnancies and outcomes?
   - ☑ Includes types of deliveries?
   - ☑ Includes medical and procedural complications of pregnancies?
5. Past Medical History
   - ☑ Complete and addresses chronic illness?
6. Past Surgical History
   - ☑ Complete?
   - ☑ Has an associated medical diagnosis in PMH?
7. Medications
   - ☑ Complete, including doses, route, and frequency?
   - ☑ Has an associated medical diagnosis in PMH?
8. Allergies
   - ☑ Complete, including associated reactions?
9. Family History
   - ☐ Complete? Any relation to chief complaint?

   suggest asking specifically if ♀ in family have heavy and/or painful periods
10. Social History
    - ☑ Complete, including social habits, occupation, domestic status, and home living arrangements?
11. Review of Symptoms
    - ☑ Complete and relevant?
12. Physical Exam
    - ☑ Appropriate general exam?
    - ☑ Complete pelvic exam?
13. Diagnostic Data
    - ☑ Relevant results?
14. Assessment
    - ☑ Includes a thorough differential diagnosis?
15. Plan
    - ☑ If surgical, includes basic operative report and findings on pathology?
    - ☑ Complete?

    How was this patient counseled give the complications
16. Practice Order Set (if inpatient)
    - ☐ Complete and relevant?

    this was not an inpatient case

ACADEMIC DISCUSSION

- ☑ Clinically relevant?
- ☑ Complete?
- ☑ Appropriate?
- ☑ Psychosocial/ethical considerations, if pertinent?
- ☑ Use of references?

OVERALL COMMENTS

Nice write-up
- you hit all the major questions we ask patients who present with AUB
- would have been nice to see some discussion on success rates on specific treatments

WRITE-UP GRADE ☑ PASS ☐ NO PASS If no pass, requires rewrite and resubmission by the following date:

INSTRUCTOR'S SIGNATURE _____ DATE _____

rev 3/27/2017

Gynecological Write Up

CC: "I'm having heavy periods"

HPI:

The patient is a 47-year-old G2P2002 (LMP) who presents for laparoscopic bilateral salpingectomy, endometrial ablation, hysteroscopy with dilation and curettage for ~~a chief complaint of~~ heavy menstrual bleeding. She states that she has been dealing with heavy menstrual bleeding for "as long as she can remember." She has been on combined hormonal contraceptives since the birth of her last child in 2001. She was recently diagnosed with hypertension and was informed by her physician that she should stop taking the combined hormonal contraceptive and start taking a progesterone only pill. The patient states that she does not like the progesterone pill as she thinks it is making her gain weight. She desires permanent treatment for her heavy menstrual periods and wishes to stop taking oral medications. The patient states that she was supposed receive an ablation 5 years ago, but she moved and never followed through with the procedure. The patient now desires to complete the endometrial ablation for her heavy menstrual bleeding.

The patient says that she only has mild cramping with her menses. Her pain usually is made better by using a heating pad. Nothing necessarily makes the patient's pain worse. She describes her pain during menses as dull and cramping and denies any radiation. She states her pain is typically a 3/10.

The patient states that she has regular menstrual cycles, however she complains of heavy menstrual bleeding. She denies any spotting outside of her normal menstrual cycle. She experiences heavy menses for the first 3 days and needs to change her pad about every hour. Her periods usually last 6 days with the last three days consisting of lighter menses where she only needs to change her pad approximately 4 times a day. She denies any history of bleeding after procedures such as tooth extractions. She does not have a history of prolonged mucosal bleeding or epistaxis. She denies a family history of any bleeding disorders. She denies any dyspareunia or post coital bleeding. As previously stated, she has minor dysmenorrhea (dull pain) but denies any chronic pelvic pain. Additionally, she denies any bowel incontinence, constipation, diarrhea, urinary incontinency, or dysuria.

The patient feels that she is constantly being "held back" by her heavy ~~menstrual~~ bleeding. She says that she is tired of temporary solutions and is ready for a permanent solution. She feels that being free of menstrual bleeding will allow her to finally "live the life" ~~she wants~~ to live without having to worry about excessive bleeding.

Gynecological History:

The patient began menses at age 12 and has had regular menses every 29 days. The patient denies any history of STDs, however she has a history of abnormal pap smears in 2016 which was followed by a colposcopy and then LEEP (histological grading of the lesion could not be found in chart review). Most recent pap and HPV testing in February of 2018 were negative along with negative gonorrhea and chlamydia cultures at that time. Currently, the patient is taking progesterone only contraceptive pills.

Obstetric History:
The patient has had two pregnancies. Her first pregnancy was uncomplicated and had a NSVD of a 8-pound 1 oz live male at 40w0d. Her second pregnancy 2 years later consisted of another uncomplicated pregnancy ending in a NSVD of a 7-pound, 9 oz live male.

Past Medical History:
Essential hypertension, active, onset 2018
Abnormal pap smear of cervix, active, onset 2016
Migraines, active, onset unknown
Episodes of infrequent vertigo, active, onset unknown

Past Surgical History:
Colposcopy, 2016
LEEP, 2016
Surgery to repair fracture in left hand, 2002
Wisdom Tooth extraction, 1987
Lasik eye surgery, date unknown

Medications:
Rizatriptan, 10 mg, 1 tab by mouth as needed for migraine relief
Lisinopril-hydrochlorothiazide 20-12.5 mg tablet, 1 tab by mouth daily for hypertension

Allergies:
No known drug, environmental, or food allergies

Family History:
Mother (alive)
- Hypertension
- High Cholesterol

Father (alive)
- Hypertension
- High Cholesterol

Brother (alive)
- Hypertension
- High Cholesterol

MGM (deceased)
- Cancer (unknown type)

MGF (deceased)
- Diabetes

PGM (deceased)
- Heart Disease

PGF (decreased)
- Stroke

Eldest Son (alive)
- No known medical conditions

Youngest son (alive)
No known medical conditions

Social History:
The patient denies a history of tobacco use and states that she drinks one glass of wine every weekend. Additionally, she denies any illicit drug use. She has her MBA and works as an office manager. She is divorced and has not been sexually active in a year. She says her support system consists of her sons as well as her parents. She lives in her own home with her children. She states she can also rely on coworkers when needed.

ROS:
Constitutional: Positive for weight change (patient thinks she has gained about 6 pounds in the last 5 months), negative for malaise, fatigue, fevers, chills, changes in appetite, weakness, or sleep problems
HEENT: Positive for occasional tinnitus but negative for changes in vision, difficulty hearing, ear pain, nasal congestion, nasal discharge, hoarseness, dysphagia, odynophagia, or sore throat
Cardiovascular: Negative for chest pain/pressure, lightheadedness, syncope, or palpitations
Respiratory: Negative for dyspnea, cough, sputum, or wheezing
Gastrointestinal: Negative for abdominal pain, nausea, vomiting, hematemesis, constipation, melena, hematochezia, hemorrhoids, bowel incontinence, changes in bowel habits, or jaundice
Genitourinary: Positive for heavy menstrual bleeding and mild dysmenorrhea but negative for dysuria, hematuria, urgency, frequency, hesitancy, urinary incontinence, nocturia, or vaginal discharge
Musculoskeletal: Negative for back pain, stiffness, or muscle weakness
Integument: Negative for rash, sores, dryness, itching
Neurological: Positive for headaches, but negative for weakness, dizziness, and syncope, paresthesia, or numbness
Psychiatric: Negative for anxiety or depression and suicidal thoughts
Endocrine: Negative for heat intolerance, cold intolerance, polydipsia, polyuria, or polyphagia
Heme/Lymphatic: Negative for pallor, easy/abnormal bruising, abnormal bleeding, or lymphadenopathy
Allergic/Immunologic: Negative for hives, hay fever, or recurrent infections

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Physical Exam:
General Appearance: Middle aged woman who appears her stated age, sitting up in no acute distress
Vitals: T 98.1 F (oral), HR 87/min, RR 18/min, BP 114/68 mmHg (left arm, seated), SpO2 98%, BMI: 32
Skin: No rashes or petechiae noted. No lesions or nodules. Skin did not appear cyanotic, skin was warm. No clubbing was observed.
Head: Skull was atraumatic, skull was symmetrical.
Eyes: No conjunctival injection, sclera was white. No uveitis present. PERRL

Ears: Not examined
Nose: Straight, nares patent, no discharge. Septum was midline.
Mouth/Throat: Mucosa was pink and moist.
Neck: Supple and nontender. Thyroid was palpable and non-enlarged.
Lymph nodes: No cervical, axillary, or inguinal lymphadenopathy.
Thorax and Lungs: Good expansion. No tenderness upon palpation. Lungs clear to auscultation bilaterally. No crackles, wheezes, or rhonchi noted.
Cardiovascular/Peripheral Vascular: No JVD noted. No carotid bruits appreciated. Radial and dorsalis pedis pulses were strong and equal bilaterally. PMI was not felt. RRR. No extra heart sounds present. No peripheral edema.
Abdomen: Flat, bowel sounds were active. Abdomen was tympanic. No masses palpated. No HSM. No CVA tenderness.
MSK: No swelling of joints, ROM was good.
Genitourinary: (Observed while in operating room with patient. Resident performed the vaginal portion of the bimanual exam while I palpated the patient's abdomen for uterus and bladder).

External genitalia:

Hair distribution appears to be consistent with Tanner stage 5 but pubic hair has been shaved by patient. Moist mucosa without obvious lesions or discharge. No evidence of cystocele, enterocele, or rectocele.

External urethral meatus: no masses or scarring
Bladder: No distention noted, no masses could be appreciated
Cervix: No discharge noted. External os was closed. No lesions present.
Uterus: Firm, smooth, mobile, and slightly retroverted.
Adnexa: No masses could be appreciated

Breast Exam:

Was not performed as no chaperone was present.

Neurological Exam:

Mental status:

Alert, oriented to person, place, and time. Speech was clear and memory was intact.

Diagnostic Data:

-Urine Pregnancy Test:

Negative

-CBC was unremarkable with Hg of 12.2, HCT of 35.6, WBC 8.3, and platelets 367.
-~~CMP was unremarkable with Na of 137, K 4.0, Cl 97, Bicarbonate 25, Ca 9.51, Albumin 4.2,~~
-Endometrial Biopsy in June 2018

"Benign polypoid endometrial tissue with decidual stromal alteration and inactive endometrial glands with no evidence of atypia or malignancy".

-Pelvic Ultrasound in June 2018:

Normal anterior midline uterus. Ovaries are visualized and appear normal. No free fluid in the cul de sac.

-Urinalysis:

Unremarkable with no leukocyte esterase, nitrites, protein, glucose, ketones, or blood present:

-Cervical swab for Gonorrhea RNA in February 2018
Negative
-Cervical swab for Chlamydia RNA in February 2018
Negative
-HPV Test from Thin Prep in February 2018:
Negative
-HIV AG-AB Combo in February 2018:
Negative
-Syphilis IgG AB in February 2018
Non-reactive
-Pap Smear in February 2018
Negative for intraepithelial lesion or malignancy

I would recommend explaining why this was dangerous

Assessment:

Patient is a 47-year-old G2P2002 who presents for laparoscopic bilateral salpingectomy, endometrial ablation, hysteroscopy, and dilation and curettage for a chief complaint of heavy menstrual bleeding. The most likely cause of her heavy menstrual bleeding is a structural cause such as an endometrial polyp. This diagnosis is supported by the fact that the patient has had evidence of a previous polyp on vaginal ultrasound. Additionally, the patient has been having heavy menses which is commonly associated with endometrial polyps. Hypertension, as well as obesity, both of which are present in this patient, may also increase the risk of endometrial polyps. This diagnosis is made less likely by the fact that the patient has not had any spotting outside of her normal menstrual cycle. Another possible cause for this patient's heavy menstrual bleeding is an inherited bleeding or clotting disorder, factor deficiency, or Von Willebrand disease. This diagnosis is supported by the fact that the patient claims to have significant bleeding especially during the first 3 days of her period where she soaks through pads every one to two hours. However, this diagnosis is less likely as the patient does not have a history of bleeding episodes. She had a wisdom tooth extraction as a young adult and did not have any complications or prolonged bleeding. She denies any history of epistaxis, gum bleeding, hemarthrosis, or hemorrhage after childbirth. Additionally, the patient does not have any family history of bleeding disorders. A third possible diagnosis is adenomyosis. This diagnosis is supported by the patient's history of heavy and prolonged menstrual bleeding. Additional risk factors which are present in this patient include childbirth and being middle aged. This diagnosis is made less likely by the mild pain the patient has during menses. Rather, it is more common for women to experience sharp, knifelike pain during their periods as well as the possibility for chronic pelvic pain.

Plan:

Diagnostic:

A hysteroscopy will be done to visualize the uterine cavity. Specifically, any polyps or fibroids will be noted. The patient will then undergo a D&C and the specimens will be sent to pathology to rule out any atypia or signs of malignancy. The patient desires salpingectomy for permanent sterility. <— also pregnancy is not recommended after ablation so sterilization is recommended ?

Therapeutic:

The patient will receive a hydrothermal endometrial ablation for her abnormal uterine bleeding with heavy menses. Additionally, the patient has chosen to undergo permanent sterilization at this time and will be receiving a bilateral salpingectomy. The ablation combined with the fact that the patient will soon be reaching menopause will lead to a significant reduction, if not elimination, of the patient's menstrual bleeding.

Patient education:

The patient has been educated on the risks and benefits of the procedure. Additionally, the patient has been counseled and understands that this procedure will leave her permanently sterile. She is agreeable to the procedure as she states she is done having children and "will be going through menopause shortly anyways". She is feeling relieved that she will no long "have to deal with heavy periods".

Operative Note:

Procedure: Laparoscopic bilateral salpingectomy, endometrial ablation, hysteroscopy and dilation and curettage

Anesthesia Type: General

Procedure details: Patient was met in pre-op. The attending discussed the risks and benefits with the patients as well as the expected outcomes. The patient gave informed consent and appropriate documentation was signed.

Once under general anesthesia, the patient was placed in the dorsal lithotomy position. She was appropriately draped. A time out was performed to ensure that the right procedure was being done on the correct patient.

~~A Foley catheter was placed. A speculum was inserted in the vagina to visualize the cervix. The~~ cervix was grasped with a tenaculum so dilation could occur. Once the cervix was dilated, a uterine manipulator was inserted into the vagina.

Laparoscopy ports were placed at the umbilicus and in the RLQ and LLQ. It was noted that the uterine manipulator had perforated through the uterine fundus. The manipulator was removed. Next, the mesosalpinx was ligated so that the fallopian tubes could be removed. This procedure was done bilaterally. The fallopian tubes were sent to pathology.

Surgicell powder was placed over the uterine perforation site. Ablation and D&C could not be performed due to the uterine perforation. Surgical sites were hemostatic before closure of the laparoscopy ports. The RLQ and LLQ ports were closed with dermabond whereas the umbilical port was closed with 4-0 Monocryl.

Silver nitrate was placed at the tenaculum site on the cervix.

Sponge, lap, and needle counts were correct.

Pathology Reports:

Fallopian tubes:

First fallopian tube as 5.2 cm in length and 0.5 cm in diameter.
The second fallopian tube was 5.8 cm in length and 0.4 cm in diameter
Serosal surfaces with brown-purple, smooth, and glistening.

Order Set:

Pre-operative EKG, urine pregnancy test, CBC with differential, and basic panel are necessary to ensure surgical readiness. After the procedure, acetaminophen 1000 mg injection and ketorolac 15 mg injection will be ordered for pain control. Motrin prescribed as needed for outpatient pain management.

Academic Discussion: Heavy Menstrual Bleeding

Heavy menstrual bleeding is a common concern for women seeking gynecological care. According to Chodankar et al., it is approximated that 30% of women have heavy menstrual bleeding. Heavy menstrual bleeding can cause emotional distress in women, as well as significantly impact the quality of life of patients. It is important to discuss a woman's goals when determining the best course of action, as well as, rule out any potentially serious causes of heavy menstrual bleeding.

According to Chodanker et al., heavy menstrual bleeding is defined as "excessive menstrual blood loss that interferes with a woman's physical, emotional, social, and material quality of life." Magnay et al. mentioned that some researchers have felt that in addition to subjective tools filled out by women outlining the effect of their menses on their quality of life, that a more objective tool is warranted. Menstrual pictograms can also be used for women to show the provider on average how much blood they are losing during their periods. Some researchers urge a more objective form of measurement such as the alkaline hematin method which can extract menstrual blood from pads for measurement. However, the alkaline hematin method has some practical disadvantages which include asking the woman to collect all sanitary items so that they can later be analyzed in the lab.

All investigations for heavy menstrual bleeding should begin with a detailed past medical history as well as a family history, surgical history, and review of medications. For example, it is not uncommon for women who have heavy menstrual bleeding to recall that their mother or other women in their family suffered from the same condition. Additionally, any history of bleeding episodes could prompt further investigation for bleeding disorders. One should ask the

patient if she has every had prolonged bleeding after a surgery or tooth extraction, ever required a blood transfusion, or every had a history of bleeding into a joint.

There are numerous causes for heavy menstrual bleeding which include coagulopathies, fibroids, liver disease (late stage), hypothyroidism, and arteriovenous malformations. Additionally, drugs such as warfarin or heparin can cause heavy menstrual bleeding (Sweet et al., 2012). According to ACOG (2012), heavy menstrual bleeding is a sub classification of abnormal uterine bleeding. Additionally, intermenstrual bleeding is another type of abnormal menstrual bleeding. ACOG has also broken down the classes of abnormal uterine bleeding into structural causes and nonstructural causes. Structural causes include polyps, adenomyosis, leiomyomas, malignancies and hyperplasia. Some of the non-structural causes that have been outlined include coagulopathy, ovarian dysfunction, endometrial causes, iatrogenic causes and causes that are not yet classified.

~~Some~~ blood tests ~~that might be~~ indicated in the work up of heavy menstrual bleeding include a CBC to rule out anemia, acute leukemias, or thrombocytopenia, and coagulation screening in people who have a family or personal history that is suspicious for a coagulation disorder. Imaging procedures can be used if structural abnormalities are suspected and might include transvaginal ultrasounds to investigate for fibroids. More invasive imaging includes a hysteroscopy which would be used to better visualize polyps or fibroids (Sweet et al., 2012).

absolutely

The treatment for heavy menstrual bleeding depends on the age of the patient as well as their desire to preserve fertility. Some hormonal therapies include progestin containing compounds. Progestins can be given in pill form or in the form of a levonorgestrel releasing intrauterine system. Non-hormonal therapies include NSAIDs. NSAIDs work by lowering prostaglandin levels which can lead to less menstrual bleeding. One study by Hall et al. showed that naproxen itself can lessen menstrual flow by 46%. Tranexamic acid has also been used to treat heavy menstrual bleeding, mostly in women with bleeding disorders. A study by Lethaby et al. found that this therapy decreased bleeding moreso than NSAIDs.

Surgical management depends on the underlying cause of heavy menstrual bleeding. Polyps will need to be removed via a hysteroscopic polypectomy. Fibroids may require resection. If a women has no desire for future pregnancies, an ablation or even a hysterectomy might be an option.

Once specific Cochrane review looked at surgery versus medical therapy for heavy menstrual bleeding. Overall, 12 different randomized control trials were reviewed. They defined medical therapy as oral medications or hormonal IUDs. Surgical therapy was defined as uterine resection or ablation and hysterectomy. They found that surgical therapies worked better with regard to decreasing excessive bleeding as compared to medical management. However, medical therapy and surgery was almost equivocal for improving quality of life.

~~Overall, heavy menstrual bleeding can significantly impact a woman's life. The "period~~ poverty" movement has recently been sweeping the internet. A study by one sanitary product line, Always, estimated that one out of every five girls have left school or missed school because they did not have access to sanitary items. Heavy menstrual bleeding can negatively affect a woman's self-confidence and can lead to a feeling of isolation. Special consideration should be given to women of other countries and cultures where menstruating is more "taboo" than in America. In foreign countries, it is not uncommon for women to be isolated to "menstrual huts" during their period and are therefore deprived of normal social interaction.

The psychosocial context of heavy menstrual bleeding changes throughout a woman's life. As previously mentioned, as a young woman, school performance may be impaired due to

heavy menstrual bleeding. Girls may become apprehensive to participate in sports as they are worried about how their heavy bleeding will interfere. Additionally, girls who attend a school where swimming is part of the physical education program may face difficulties as well. As a girl matures, she may feel like her job performance is affected by her heavy periods. As she enters the workforce, she will strive to make a good impression, however, she might find herself needing to take more days off of work than her male counterparts. This not only affects her job productivity but affects her paycheck as well. Women may feel apprehensive about entering certain career fields such as surgery or military training as these jobs require long working hours without breaks. A woman may be concerned about her ability to change her sanitary item in a timely manner to avoid accidents.

Sources:

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