CARING CENTER FOR WOMEN, P.A.

Annual Exam/Preventive Maintenance for YOUR BODY

I. SCREENING TEST for CANCER

A. Pap Test (screening test for cervical cancer). This is based upon the joint recommendations by the American Cancer Society (ACS), the American Society for Colposcopy and Cervical Pathology (ASCCP) and the American Society for Clinical Pathology (ASCP).

1. **First screen**—Screening of cervical cytology (cervical cells) should begin at age of 21, regardless of sexual initiation.

2. Women **aged 21 to 29**: should be tested with cervical cytology **only** and done every three (3) years.

3. Women **aged 30 to 65 :** have 2 options:
   a) tested with cervical cytology alone every 3 years
   b) tested with cervical cytology and HPV (Human PapillomaVirus) testing every 5 years

4. Women who have a **history of cervical dysplasia (precancer) cervical cancer**, have **HIV (Human Immunodeficiency Virus) infection**, are **immunocompromised**, or were exposed to **diesthylstilbestrol (DES)** in utero, should **not** follow routine screening guidelines. Screening recommendations will be determined by your provider, which can be anywhere from every six (6) months to every year.

5. **After hysterectomy with removal of the cervix** (not a supracervical hysterectomy, where the cervix is left in place) and have **never** had CIN 2 or higher (moderate dysplasia, precancerous cells of the cervix): discontinue Paps completely.

6. If there is a **history of CIN 2 or greater**, then routine AGE-BASED screening for 20 years after the initial post-treatment surveillance period should continue, even if it requires that screening continue past age 65 years AND even if a hysterectomy has been done (with or without removal of the cervix).

7. Screening should be discontinued after age 65 years in women with evidence of adequate negative prior screening results and no history of CIN 2 (moderate cervical dysplasia or higher).

8. In women who have had a hysterectomy with removal of the cervix and have never had CIN 2 or higher, routine cytology screening and HPV testing would be discontinued and not restarted for any reason.

9. **FOR POSITIVE HPV TESTS, BUT NEGATIVE CYTOLOGY,** there are 2 options:
   a) HPV genotype-specific testing for HPV 16/18:
      (i) if positive, will need further testing with a procedure called a colposcopy that involves a cervical biopsy.
      (ii) If negative, co-testing in 12 months.
   b) repeat co-testing (cytology and HPV) in 12 months.

10. Some women however, don't feel comfortable and prefer more frequent screening. Most insurance companies still cover annual Paps, EXCEPT MEDICARE! You are responsible to letting your provider know that you desire a pap, even if not recommended and may be responsible for any costs related to this.

11. **REMEMBER, even though Paps are not necessary annually for every woman, pelvic and breast exams are! Collecting the cervical cells at an annual exam is only a small component of an annual exam. Your annual exam is exactly the same; the only difference being the absence of cervical cell collection.**

B. Breast Exam and Mammography (screening tests for breast cancer)

1. Clinical breast exams (one which is done by a health care provider) are recommended on an annual basis. They do not have to be performed prior to your mammogram.

2. Self breast exams are recommended on a monthly basis, the week after your menstrual period begins (or same time each month) if still cycling.

3. American Cancer Society (ACS) recommends annual mammography for women beginning at age 40. No longer necessary to obtain routine baseline mammograms in women younger than 40 years.

4. If you have a **first degree relative** (mother, father, sister, brother) with breast cancer, mammography should begin 10 years before age of diagnosis in 1st degree relative and annually thereafter.

5. Thermography is not considered the standard of care for breast cancer early detection.

6. Breast cancer screening should be discontinued at 75-80 years of age because the benefit-to-risk ratio of screening mammography continues to shift adversely with advancing age. An agreement of recommendations does not exist.

C. Colorectal Cancer Screening

The USPSTF (U.S. Preventive Services Task Force) recommends that clinicians screen men and women 50 years of age or older for colorectal cancer. Screening may be done with fecal occult blood testing (FOBT; looking for hidden blood in the stool) yearly, or in combination with colonoscopy every 10 years. Signs of colon cancer include rectal bleeding (stool may be black or tarry or frankly bloody), abdominal pain, and/or a change in bowel habits/stool size and shape.

1. **Fecal occult blood testing** reduces mortality. It ideally should be done on 3 separate stools. Annual screening over age 50 is recommended.

2. **Colonoscopy** alone or in combination with FOBT reduces mortality. It is recommended every 10 years. We recommend San Marcos Gastroenterology Associates. Their phone number is: (512) 754-8676.

II. OTHER SCREENING TESTS

A. Heart and Vascular Disease Screening

1. The USPSTF strongly recommends that clinicians routinely screen women aged 45 years and older for lipid (cholesterol) disorders.

2. USPSTF recommends that clinicians routinely screen women aged 20-45 for lipid disorders if they have other risk factors for coronary heart disease

    - Diabetes
    - Family history of cardiovascular disease before age 50 years in male relatives or age 60 years in female relatives
    - Family history suggestive of high cholesterol/lipids; multiple coronary heart disease risk factors (e.g., tobacco use, high blood pressure).

3. The optimal interval for screening is uncertain. Reasonable options include every 2-5 years, shorter intervals for people who have lipid levels close to those warranting therapy, and longer intervals for low-risk people who have had low or repeatedly normal lipid levels. An age to stop screening is not established. Screening may be appropriate in older people who have never been screened, but repeated screening is less important in older people because lipid levels are less likely to increase after age 65 years.

B. Fasting Blood Glucose (blood sugar/diabetes screen)

1. The USPSTF concludes that the evidence is insufficient to recommend for or against routinely screening asymptomatic adults for type 2 diabetes.

2. The USPSTF recommends screening for type 2 diabetes in adults with high blood pressure or high cholesterol/lipids.

3. We may screen those adults with:
   - Family history of type 2 DM
   - Gestational diabetes
   - Hispanic, African American, Native AM, Asian, or Pacific Island heritage
   - Obesity, see BMI chart

4. Symptoms of diabetes include urinating too frequently, feeling very thirsty and hungry, despite drinking and eating appropriately, losing weight, sugar in urine, high triglycerides/low HDL (good) cholesterol.

5. Women who had gestational diabetes (diabetes in pregnancy) have a 50% chance of becoming diabetic within 5 years of the birth of their child.

C. Thyroid Function Testing

USPSTF found fair evidence that the thyroid stimulating hormone (TSH) test can detect subclinical thyroid disease in people without symptoms of thyroid dysfunction, but poor evidence that treatment improves clinically important outcomes in adults with screen-detected thyroid disease. Certain groups are at higher risk for thyroid disease and may be screened on a case by case basis:

- Postpartum women
- Those with Down Syndrome
- Women > 50 years old
- Those with personal/family history of thyroid problems\those with autoimmune disease
- Use of lithium or amiodarone
- Have symptoms of:

1) low thyroid hormone production—dry skin, fatigue, weight gain, puffy hands/face, cold intolerance, constipation, hair loss, menstrual irregularity;
2) high thyroid hormone production—nervousness, sweating, trembling, palpitations, heat intolerance, weight loss, fatigue, menstrual irregularity.

D. BONE MINERAL DENSITY SCREENING

1. Risk factors for osteoporosis
   - Personal history of fracture as an adult
   - History of fragility fracture in a first-degree relative
   - Low body weight (approximately less than 127 lbs)
   - Current smoking
   - Excess alcohol use (more than 2 beverages per day)
   - Eating disorders: Anorexia Nervosa, Bulemia Nervosa
   - Use of oral corticosteroid therapy for more than 3 months
   - Caucasian (white) or Asian race
   - Postmenopausal, not on hormone replacement therapy

2. Additional risk factors for fracture:
   - impaired vision
   - estrogen deficiency at an early age (<45 yrs)
   - dementia
   - poor health/frailty
   - recent falls
   - low calcium intake (lifelong)
   - low physical activity
   - alcohol in amounts of >2 drinks per day.

3. Who should be tested?

The decision to test for BMD should be based on an individual's risk profile, and testing is not indicated unless the results could influence a treatment decision. BMD testing should be performed on:

- All women aged 65 and older, regardless of risk factors
- Women aged 50 to 64 with one or more risk factors: see #1 & 2 above (other than being white as the only risk factor)
- Fractures after age 50
- Conditions associated with bone loss: chronic obstructive pulmonary disease (COPD), rheumatoid arthritis (RA), hyperparathyroidism, celiac disease, irritable bowel disease (IBD)
- Medications associated with bone loss: aluminum, anticonvulsants (phenobarbital, phenytoin), cytotoxic drugs, glucocorticosteroids (prednisone) and adrenocorticotropin; gonadotropin-releasing hormone agonists; immunosuppressants; lithium, long-term heparin use, depo-provera); high thyroid hormone doses; tamoxifen (premenopausal use); total parenteral nutrition (TPN).

ALTHOUGH THE ABOVE IS THE RECOMMENDATION, YOU MUST CHECK WITH YOUR INSURANCE BECAUSE THEY MAY NOT COVER SOME OF THESE TESTS!!

III. DISEASE PREVENTION

A. **PREVENTION OF OSTEOPOROSIS/ OSTEOPENIA** (conditions which are caused by decreased minerals in the bones, leading to a higher risk in bone fractures).

1. Calcium daily intake recommendations in mg per day (includes calcium found both in dietary products AND supplements):

   a. women aged 14-18: 1100-3000

   b. women aged 15-50: 800-2500

   c. women aged 51 and older: 1000-2000

2. Vitamin D daily intake recommendations for ages 14 and above: 400 IU up to 4000 IU per day. This is dependent upon your dietary intake, level of direct sun exposure and blood levels of vitamin D. Evidence suggests that low vitamin D intake is associated with several different types of cancer (including breast cancer), depression, anxiety and weight gain.

3. Recommended supplements:

   a. Osaplex (contains calcium, vitamin D and collagen—as a "side benefit, collagen was found to reduce wrinkles and improve hair and nails), Activessentials (contains comprehensive multivitamin, calcium and vitamin D). These products are produced by Xymogen). Two other great options are Probono by Orthomolecular and Usana supplements.

   b. Calcium can cause constipation. If this is a problem, take a calcium supplement with magnesium. If you become nauseated, take at night or try calcium chews.

   c. Calcium supplements have recently come into question. There are studies that showed individuals who took non-dietary calcium supplements, especially when NOT combined with vitamin D, had a higher risk of heart attack. However, these were incidental findings, and more studies are ongoing to better answer this question. The concern appears to relate to supplements only, not calcium containing foods. The best approach is therefore to eat a healthy diet, but for women with specific osteoporosis risk factors or known osteoporosis, additional calcium supplementation in combination with vitamin D may still be appropriate.

4. Weight bearing exercise; walking, jogging/running, bike riding, aerobics (zumba), weight training, stair climbing, using an elliptical machine, playing tennis, boot camp,

etc. (anything that places weight on your feet) is recommended for 30 minutes, most days of the week (ie., at least 4 days per week).

5. Prescription medications, such as Fosamax, Actonel, Boniva, Evista or Forteo, can be recommended for those with osteopenia or osteoporosis. These prescriptions are based upon each individual's risk assessment.

B. PREVENTION OF HEART DISEASE, HIGH BLOOD PRESSURE, DIABETES, AND CANCER

1. Multivitamins, that contain at least 0.4 to one mg of folic acid, 400 IU of vitamin E and 1000 mg of vitamin C is recommended to help prevent the above-mentioned diseases.

   a. Folic acid has been shown to decrease the risk of heart disease. Heart disease is the most common cause of death in women over 45 years old (one in three women will die from this). Folic acid will also decrease the risk of colon cancer, which is the third most common cause of cancer death in women.

   b. Omega-3 fatty acids, 1000-2000 mg daily can prevent heart disease. Some studies show improvement in memory, as it decreases cholesterol. Diets high in cholesterol and polyunsaturated fatty acids have a link to Alzheimer's disease. In addition, Omega-3 fatty acids improve memory by decreasing "pro-inflammatory chemicals" that are responsible for cognitive decline.

      Examples of supplemental products, which contain the above include: Xymogen's Activessentials, Orthomolecular or Usana products.

2. Exercise

   a. Exercise has been shown to decrease breast cancer by almost 15% in women aged 18-50 years, if they engage in strenuous physical activity.

   b. It is better to be fit and fat, than not fit and of normal weight. The fitness level is a better predictor of cardiovascular disease. In a study of >7500 women, rates of heart disease were lower among those who became or remained active, even if not of normal weight, than those who remained sedentary. Also, fit people have sharper brains.

   c. **Minimum physical activity recommended:** Aerobic exercise, moderate to strenuous activity that increases the heart rate, for 30 minutes, most days of the week. Pedometers can be useful. The average person takes <300 steps/day. Public health guidelines call for a minimum of 10,000 steps a day.

   d. For weight loss, one needs to exercise 60-90 minutes per day, 5 sessions per week (or 12,000- 15,000 steps per day).

   e. If you are sedentary (not active), start an exercise program slowly. That is, 10 minutes per day, and work up slowly (increase by 10-20 minutes each week)

toward your goal. However, benefits may occur even with bursts of only 8 – 10 minutes of exercise.

f. The target heart rate should be 220 minus your age, and then multiplied by 60-80%. For example, if you are 30 years old, first subtract 30 from 220 to get 190, then multiply 190 by 0.6 to 0 .8, and you will get from 114 – 152 beats per minute).

g. Stop if you experience a shortness of breath, chest pain, or dizziness, and notify your primary care provider, or go to the emergency room.

3. Diet low in fat, cholesterol, and calories.

a. Daily intake should be divided as 50% carbohydrates, 20-30% protein and 20-30% fat.

b. For those trying to lose weight, you should increase protein to 35-40%, decrease carbohydrates to 45-50%, fat to 10-15%. A good rule of thumb is to consume one gm protein for every one lb of your desired weight. For example, if you desire to be 150 lb, then consume 150 gm pro (or 600 cal protein, as 1gm pro = 4 cal).

c. For heights between 5' and 6', calories should be between 1200-2200 calories/day, respectively. This can be calculated by multiplying 25 by the number of kilograms of your ideal weight. That is, a body mass index (BMI) between 18-25. For example, at 5' 8", BMI of 18-25 is 120 (or 55kg) to 170lb (or 77kg); 25 calories multiplied by 55-77 is approximately 1375-1925 calories/day. Add 300 calories per day for every 30 minutes of aerobic exercise.

d. Drink at least 8 to 11 eight-ounce glasses of water per day.

4. Ideal weight maintenance---BMI between 18-25---this is your height to weight ratio, which can be found on a graph in your provider's room or on the Internet. The following are a few tips for those trying to lose weight:

a. Portion control is the key. Since the 1970's, obesity has increased from approximately 40% to approximately 70%. This is primarily due to the larger portions we consume. Restaurants are notorious for serving large portions, which we then to try to emulate at home.

b. Drink a full liter of water prior to each meal, so your overall intake is less (simulate a gastric stapling procedure, as there is now less room for food).

c. If "seconds" are desired, wait 10 minutes. By then, the thought is almost gone (due to time constraints or preoccupation with the next task).

d. Do not deprive yourself of anything. However, just eat a very small amount to satisfy the craving. For example, take 2-3 bites only from a cheesecake, or one small cookie, or 10 peanuts, or 10 chips (and actually sit down and count them). Because once you step beyond this, it is harder to stop.

e. Eating more meals per day (for example, 6 small ones) is healthier than 3 large meals, and will help you lose weight, even if you eat the same number of calories.

f. Chew sugarless gum, suck on sugarless candy with cravings.

g. Remember it is OK to fail, but pick yourself up and get back on a healthy diet and exercise plan!

5. Stop smoking---notify your provider for assistance with this issue.

6. Moderate alcohol consumption (unless you have preexisting liver, stomach, gallbladder, or colon problems) ---1 to 2 alcoholic beverages per day: For example, 4 oz. wine or 8 oz. beer or 1 oz. hard liquor. You should not save up all week, and drink 10 in one night!!!