PRIVATE PARTS:
A Brief Overview of Females' "Top" and "Bottom" Issues

OBJECTIVES
As a result of this session, the learner will:

1. Identify different types of breast lumps & nipple issues

2. Identify signs & symptoms of vaginal bleeding/discharges and be knowledgeable to refer these conditions

3. Evaluate a pregnant female with vaginal bleeding and/or possible onset of labor and be able to assist in her care
"Top" Issues

1. Mastitis/Breast Abscess
2. Nipple discharge
3. Inverted nipples
4. Breast Lumps:
   - Fibroadenoma/Papilloma
   - BRCA

"Bottom" Issues

1. Dysmenorrhea - Primary
2. AUB
3. Vaginal Issues/Discharges
   - Trichomonas
   - Bacterial vaginosis
   - Vulval candidiasis
   - GC
   - Chlamydia
   - HSV 1 & 2
4. Pregnant Women
   - Vaginal bleeding
   - Placenta previa
   - Placenta abruption
   - Emergency childbirth

The Breast

Mastitis of the Breast

- mastitis is infection/inflammation of the breast tissue or mammary glands

Symptoms of Mastitis

The main symptoms of mastitis are:
- breast pain
- swelling
- redness
- fever
- enlargement
- changed nipple sensation
- discharge
- itching
- tenderness, and/or a breast lump.
Mastitis of the Breast

**DIAGNOSIS**

- The infected breast is red, swollen, warm, tender to the touch
- possible fever and malaise
- refer to clinician due to chance of breast abscess forming

**Mastitis of the Breast**

**TREATMENT**

For bacterial mastitis

- **Antibiotics**
  - dicloxacillin, emycin, cephalosporins, or penicillin
  - usually for 10-14 days

- **Other**
  - warm packs, analgesics also help
  - refer to clinician due to chance of breast abscess forming

Breast Abscess

- centralized collection of pus in the breast tissue
- caused by mastitis or cellulitis that didn't respond to antibiotic therapy
- occurs more frequently in women who are:
  - African American
  - obese
  - women who smoke
Breast Abscess

CLINICAL EVALUATION

- manifests as localized, painful, inflamed breast with a fluctuant point tender mass
- fever and general malaise usually occurs
- time of onset varies from 5-28 days after treatment for mastitis or if mastitis is not treated

Breast Abscess

ANTIBIOTIC THERAPY

- include Bactrim, clindamycin, Keflex, and Dicloxacillin
- surgical drainage

Breast Abscess

DIAGNOSIS

- most common organisms are staph aureus or MRSA
- ultrasound of the breast will identify abscess or mastitis

Nipple Discharge
Nipple Discharge

- 50-80% of women can express drops of fluid during their productive years
- Most discharge is benign
- Goal of assessment is to eval if benign or cause of high risk condition or cancer

Nipple Discharge

CAUSES (continued)

Neurogenic stimulation
- handling excessively or manipulation of areolar area, ill-fitting bras, even warm shower to area can cause nipple discharge that is clear to milky

Pathologic or suspicious discharge
- usually unilateral, isolated to a single duct
- causes spontaneous, persistent serous-sanguinous → serous discharge
- Papilloma is most common = tumor growing from lining breast duct

Nipple Discharge

CAUSES (continued)

Galactorrhea
- non-pathologic bilateral or unilateral discharge that is usually milky-white, but can be yellow, green, tan, or gray
- usual cause is an increased prolactin level
- possible pituitary tumor
- galactorrhea from sedatives, antidepressants, antipsychotics, HTN meds, cocaine, marijuana or opioid use

Malignancy of breast
- ductal carcinoma or Paget's Disease
- grossly bloody discharge → sticky straw-colored should be referred for evaluation
Nipple Discharge

**CLINICAL EVALUATION**
- good history → is there family history of breast biopsies or cancer?
- clinical breast exam
- milk from base areola (to check if discharge present)
- observe if from one or multiple ducts
- guaiac if bloody discharge
- Dx mammogram and ultrasound

**PATIENT EDUCATION**
- Side effects of certain medications
  - if bothersome refer to med change
- advise not "checking" for discharge
- shower with back to water source
- refer to practitioner any discharge that isn't milky, or obvious med related side-effect,
- Inform psych practitioner if potential for galactorrhea is medication related

Nipple Inversion (retraction)

*This segment is for women with recent development*

- causes of "acquired" inversion include mammary duct inflammation or mastitis, ductus conditions, areola abscesses or malignancy

**Nipple inversion caused by Malignancy**

inversion can be from the main breast or subareolar malignancies
- incidence is between 5-50%
- presents as asyemtric and distorts the areola
Nipple Inversion (retraction)

**DIAGNOSIS**

- Good self breast exam and/or clinical breast exam
- Diagnostic mammography and diagnostic ultrasound
- Refer/contact upper level provider for directives

Benign breast lumps

- Breast lumps can be located anywhere on the breast
- Normally found upon palpation
- Occur bilaterally or unilaterally
- Present as painless or painful breast mass that usually has a clear to discolored nipple discharge

- Usually create anxiety and fear until proven benign (especially if found on diagnostic imaging)

Benign breast lumps

- Can present as one midsize lump near the nipple or several smaller lumps distant to the nipple area - papilloma
- Can be painful and larger, can also enlarge the breast
- Small tumor in breast duct and are "wart-like" growths of gland tissue along with fibrous tissue and blood vessels
Benign breast lumps

- usually this condition DOES NOT increase chances of breast cancer unless:
  - positive biopsy result
  - "multiple papillomas" can predispose condition atypical hyperplasia or precancerous cells in breast

papilloma

intraductal papillomas most common in women aged 35-55 y/o

Simple fibroadenomas

- benign solid tumors made up of fibrous & glandular tissues
- occur in ages 15-30 year olds
- presents as a rubbery, well defined, solid, "mobile mass, that rolls", usually non-tender
- feels like a marble, smooth upper outer quadrant

Simple fibroadenomas
Simple fibroadenomas

- average size 1-3cm for simple, occasionally can grow to 5-6cm
- can shrink and resolve on their own
- cause is unknown but is believed to be driven by hormones like pregnancy or estrogen therapy including OCP

CLINICAL EXAM

- clinical breast exam
- ultrasound
- mammogram
- once diagnosed, can remain in breast or be excised
- excision may leave dimpling or distortion
- it may grow back or others may form
- non-urgent condition but verify lump with upper level provider

Simple fibroadenomas

- can present as single lump (simple) or multiple lesions clustered (complex)
- whether simple or complex, doesn't increase chance of breast cancer
Breast cancer

- 1 in 8 women will develop breast cancer in her lifetime
- 2nd most frequent cancer in the world; most common malignancy in women leading to death
- it is however, the most preventable if caught early
- annual mortality rates have decreased over the past decade, however more in Caucasian than African Americans

Breast cancer

- breast cancer is a type of cancer where malignancy cells divide slowly over time
- 80% originate in the mammary ducts (ductal carcinoma)
- 20% arise in the lobules (lobular carcinoma)
- effects predominantly female ... but males can get breast cancer too (1-2%)
- risk increases with full-blooded sisters with BRCA diagnosis
- most common areas are:
  - upper outer quadrant of breast
  - under the nipple/areola

Breast cancer

**RISK FACTORS**

- incidence increases with age; highest group 50-75 years old
- Caucasian race (though African Americans close behind)
- obese, smokers, ↑ fat diet, women who drink >2 ETOH per day
- menarche before age 11 or after age 14
- menopause after age 55 or >35 years of menstruation
- nulliparity (never being pregnant)

Breast cancer

**RISK FACTORS (continued)**

**Family Medical History**

- mother with breast cancer ↑ risk by 20% (for women)
- additional family members ↑ risk additional 10-15% EACH
- the younger the female relative diagnosed... the greater the risk!!!
- FMH of ovarian cancer ↑ risk; probably due to an inherited genetic mutation (BRCA-1 or BRCA-2)
  i.e. Angelina Jolie
After losing her mom, grandma, and aunt to cancer, she elected to have double mastectomy first as risk was higher for breast than ovarian then had blood test marker CA125 which showed early sign for ovarian CA, she had her ovaries removed.

**What's #1 action in which women discover possible breast cancer??**

**ANSWER:**
Dressing in front of, or cleaning the bathroom mirror!!!
Breast cancer outside of the Breast

- Intramammary lymph nodes are detected in 1-28% of women with breast cancer and does worsen the prognosis

Tail of Spence

- axillary tail and is an extension of the tissue of the breast that extends into the axilla
- vital to all self and clinical breast exams as this area can harbor breast cancer even though it might not be in the breast proper

Breast cancer

<table>
<thead>
<tr>
<th>TREATMENT</th>
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<tbody>
<tr>
<td>depends on cancer type, staging, or advanced metastasis</td>
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<tr>
<td>- Tamoxifen P.O. <em>(not longer than 5 years or 1 chance of uterine CA)</em></td>
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<tr>
<td>- Chemo</td>
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<tr>
<td>- Radiation</td>
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<tr>
<td>- lumpectomy with or without lymph node removal</td>
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<tr>
<td>- radical mastectomy one of both breasts</td>
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<tr>
<td>- removal of ovaries???</td>
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Breast cancer

<table>
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<tr>
<th>DIAGNOSIS</th>
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<tbody>
<tr>
<td>- mammography</td>
</tr>
<tr>
<td>- targeted US</td>
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<tr>
<td>- Breast MRI</td>
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<tr>
<td>- surgical biopsy</td>
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<table>
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<tr>
<th>NO NEEDLE BIOPSIES</th>
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<tr>
<td>- can cause site bruising or an inflammatory process, distortion to the mass, and increase the size of the lymph nodes</td>
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Breast cancer

<table>
<thead>
<tr>
<th>PREVENTION</th>
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<tbody>
<tr>
<td>- self breast exams</td>
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<tr>
<td>- clinical breast exams</td>
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<tr>
<td>- mammograms <em>(age 40 per Gail Risk factors, otherwise age 50; DOC = 50 y/o)</em></td>
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<tr>
<td>- reporting any breast lumps or distortion to breast</td>
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<tr>
<td>- &quot;limited&quot; genetic testing for BRCA 1&amp;2</td>
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Breast cancer

PREVENTION (continued)

- **healthy lifestyle:** low fat diet, healthy weight, exercise activity, no smoking

- know family medical history DETAILS and comply with genetic evaluation if deemed applicable

- limit HRT (hormone replacement therapy) to maximum of 5 years secondary to ↑ estrogen use over time (based on WHO 20+ year study)

Breast cancer

PATIENT EDUCATION

- look up “Gail Risk” to lower anxiety

- obtain good health history - including FMH and any breast surgery history

- encourage self breast exams → include outer breast, armpit, and lymph nodes

"Bottom" Issues

1. Dysmenorrhea - Primary

2. AUB

3. Vaginal Issues/Discharges
   - Trichomonas
   - Bacterial vaginosis
   - Vulvar candidiasis
   - GC
   - CHL
   - HSV 1&2

4. Pregnant Inmates
   - Vaginal bleeding
   - Placenta previa
   - Placenta abruption
   - Emergency child birth

Female Reproductive Anatomy
Dysmenorrhea – Primary

- recurrent crampy, lower abdominal pain occurring during menstrual cycle
- pain is usually in the lower abd, supra pubic area, lower back or even radiating thigh pain
- Duration can be 1-2 days prior to menses and last up to additional 72 hours on average

CAUSES
Prostaglandin hormonal release from the endometrium during sloughing; is the main cause of uterine contractions

Dysmenorrhea – Primary

DRUG THERAPY
First-line pharmacologic therapy is the use of NSAIDS

- Ibuprofen and Naproxen being the most common
  - Ibuprofen 400-600mg every 4-6 hour or 800mg every 8 hours (Max 2400mg per day) with food always!
  - Naproxen 500mg every 12 hours
- Dosing should start at onset of cramping or spotting and be encouraged cyclically/continuously for duration of symptoms

- Tylenol doesn’t show much benefit due to lack of prostaglandin effect
- Use of contraception - OCPs, Depo (will be discussed shortly)

Treatment
Heat = warm packs (heating water to saturate wash cloth) has shown to be the most effective non-pharmacologic therapy.

Exercise = walking, yoga, stationary activities like stretching, jumping jacks, squats, slow-paced sit-ups or crunches also showed benefits in clinical trials

Diet = ↑ dairy intake, ↓ fat

Combining heat with anti-inflammatory agent in clinical trials proved to be most beneficial
**Dysmenorrhea – Primary**

Heat, exercise, relaxation techniques should be encouraged during education piece

**Monthly menstrual calendars =**

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**AUB/DUB = abnormal/dysfunctional uterine bleeding**

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**Dysmenorrhea – Primary**

**Refer women:**
- with extreme ↑ volume bleeding especially if large clots and abdominal pain continues with NSAID use
- on menses that saturate pad in 20-30 minutes (pad checks should be witnessed by nursing)
- women with abnormal vital signs (↑ temp, ↓BP), skin pallor, emesis, fainting could be signs of miscarriage, pelvic infection, or possible foreign body

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**Abnormal Uterine Bleeding (AUB)/Dysfunctional Uterine Bleeding (DUB)**

**defined as:** uterine bleeding outside of the normal menstrual parameters or "intermenstrual" bleeding

- heavier than normal flow or flow >80cc, 30cc=1oz (chronic loss of 80mLs per cycle → anemia)
- can be spotting → hemorrhage
Abnormal Uterine Bleeding (AUB) / Dysfunctional Uterine Bleeding (DUB)

- both terms used by medical practitioners now but preferred AUB
- used to be called meno metrorrhagia

CAUSES due to a complex cycle of disrupted estrogen, progesterone, hypothalmic-pituitary-ovarian axis and endocrinologic factors

AUB/DUB

AUB is most common non-annual gyn visit

- approx 10-35% of all women have some form of AUB depending on age group

Other factors include:
- medication side effects (esp. psych meds)
- sexually transmitted infections
- miscarriages (incomplete miscarriages)
- pregnancy
- excessive exercise
- eating disorders

AUB/DUB

Reproductive years
- pregnancy
- benign growths (fibroids/polyps)
- medication induced
- endocrine or liver disease
- clotting disorders

Peri-menopausal
- irregular ovulation
- benign growths
- cancer

AUB/DUB

Menopause = 1 year absence without any vaginal bleeding

Post-menopausal
- medication induced
- benign growths (fibroids/polyps)
- cancer
- endometrial lining and uterine atrophy

*onset of post-menopausal bleeding in women is referred immediately for transvaginal ultrasound or biopsy and is assumed endometrial cancer until proven otherwise
AUB/DUB

DOCUMENTING AUB

- Regularity: regular, irregular, or absent
- Duration of flow: normal, prolonged, or shortened
- Frequency: normal, frequent, or infrequent
- Volume: normal, heavy, or light
- Pad use - how many per hour/day

AUB/DUB

CAUSES

- Pregnancy is #1 cause
- Endocrine disease - hypothyroidism
- PSOC (polycystic ovary syndrome)
- Hematologic disorders i.e. Von Willebrand
- Cushing's Disease
- Increased stress
- Medications (OCPs, IUDs, anticoagulants, corticosteroids)
- Morbid obesity
- Fibroids, polyps, malignant lesions
- Presence of a foreign body
- Drug use!!!

AUB/DUB

CLINICAL EVALUATION

- check HCG

Refer to ACP for possible:
- pelvic exam
- STD (STI?) testing
- Transvaginal/Pelvic ultrasound
- lab orders: CBC, TSH, PT/PTT (hypothyroidism is common cause)
- Gynecologic evaluation - possible foreign body

AUB/DUB

EDUCATION

Monthly menstrual calendars: patient can do herself, various menstrual logs are available online

Research her medication list: possible side effects/causes of issue (esp. newly prescribe meds)
**AUB/DUB**

**TREATMENT (CONTINUED)**

**OCPs/Hormonal contraception:** for women with documented dysmenorrhea or AUB by history or failure of NSAIDS

- These contraceptives suppress ovulation and cause the endometrial layer to thin over time
- They also regulate hormonal levels; end result should be lighter, shorter, less crampy and clotty cycles

**Injectable contraception:**
Depo Provera 150mg IM D. Gluteal q 3 months (do not give in deltoid)

- ~50% of women receiving Depo will become amenorrheic (anywhere from immediately to 6 months after continued doses due to endometrium atrophic changes)
- Best effects when given on Day 3-5 of menses; this decreases BTB, spotting as potential side effects
- Other side effects to educate pt for new depo users = fatigue, moodiness, hair loss (more reported in African American women), weight gain due to increased appetite

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**Vaginal discharges**

- **Ovulation**
  - occurs mid menstrual cycle (28 days) approx 10-14 days on avg for most women
  - ↑ in serum estradiol cause early thickening of endometrial layer and ↑ cervical mucous
  - "snot-like" or "stringiness" (known as spinnbarkeit) is a noticeable discharge
  - can be mistaken for an STI
  - education, reassurance, menstrual diaries, and explanation that this assists in sperm transit to the uterus
Vaginal discharges

Normal vaginal fluid pH is usually between 4 and 4.5

- Candida overgrowth = < 4.0
- Bacterial overgrowth = > 5.0
- litmus paper testing in jail setting?

Trichomonas vaginalis
Sexually transmitted protozoan

- spread by sexual transmission
- very rare transmission by inanimate objects has been documented i.e. toilet seats
- incubation period 4-28 days
- coexistence of trich and BV can commonly occur in 60-80% of cases
**Trichomonas vaginalis**

**SYMPTOMS**
- present as malodorous, thin “bubbly” yellow-green, “soupy” discharge

Other symptoms include:
- pruritus
- burning
- UTI-like symptoms
- Lower abdominal discomfort (in approx 40%)

Symptoms can worsen during menstruation

**Trichomonas vaginalis**

**SYMPTOMS (continued)**
- if untreated, trich can lead to urethritis, cystitis, PID (esp if HIV+)

**EDUCATION**
- nurses can look at panties or pads for discharge of external visualization of vaginal vault
- upper level provider will see "strawberry" cervix and cervical OS drainage with odor

**Trichomonas vaginalis**

**TESTING**

Tests include:
- culture swab
- urine

**TREATMENT**

Metronidazole/Flagyl or Tinidazole
2grm PO
- 1 dose of either

**TREATMENT (continued)**

Vaginal therapy
- Metronidazole/Flagyl gel has lower cure rate

**Patient education**

No ETOH for 24-72 hours after treatment
- due to antabuse reaction = perfuse vomiting
- Pill coating has metallic taste - inject quickly and food after
- Urine can turn blue, brown, or black
Trichomonas vaginalis

TREATMENT (continued)

TOC recommended

• 4 weeks after treatment completed - or can still detect trich positive (dead antigen)

Treatment failure with Flagyl (Flagyl resistance) is rare but occurs; then Tinidazole use is appropriate

Bacterial Vaginosis

• most common cause of vaginal discharge (that is not an STI)

• like candida, BV is change in vaginal flora via imbalance produces lactobacilli overgrowth and pH rises

• usually due to women causing imbalance i.e. over washing area or wearing pads/pantyliners when not menstruating

Bacterial Vaginosis

TRANSMISSION

• BV is sexually transmitted through penetration/intercourse

• BV is prevalent in women who have sex with women

• oral sex, finger penetration, dildos and inanimate objects effect vaginal flora
Bacterial Vaginosis

**SYMPTOMS**
- women can be asymptomatic, otherwise c/o thin, off-white/grayish odorous/fishy smelling discharge

- usually doesn't cause burning, itching, dysuria and/or vulvar irritation like candidiasis

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Bacterial Vaginosis

**TESTING & DIAGNOSING**

- physical exam and litmus paper to check pH, C&S

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Bacterial Vaginosis

**TREATMENT**

- No need to treat sexual partners unless symptomatic

- Metronidazole (Flagyl) PO or vaginally
  - 5-7 days

  or

- Clindamycin vaginally
  - if intolerant to Flagyl

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Bacterial Vaginosis

**TREATMENT (continued)**

- No need to treat sexual partners unless symptomatic

- Tinidazole
  - Flagyl alternative
  - small chance of Flagyl resistance

- **Probiotics** have been used with many antibiotics as adjunct therapy, but there is no evidence it is helpful

- **Yogurt** = no evidence
Bacterial Vaginosis

Pregnant women need to be treated as BV can lead to increased risk of pre-term delivery.

Bacterial Vaginosis

Vaginal discharges that are copious, over-abundant, foul-smelling, and don't fit in any other category should be referred for culture.

Group B strept, proteus, and pseudomonas have been found.

Vulvovaginal candidiasis

- Inflammation of vulvar vaginal region secondary to overgrowth of yeast organism known as candida albicans.

- 2nd most common cause of vaginitis (BV is #1).
Vulvovaginal candidiasis

SYMPTOMS
vulvar itching, burning, "cottage cheese"-like discharge, soreness, circumscribed plaque with erythem base fissures, musty odor

- can be spread from rectal area and migrate to vagina
- can be sexually transmitted

TESTING
checking vaginal fluid pH, culture and sensitivity, wet mount, lab

Vulvovaginal candidiasis

Predisposing factors include: pregnancy, diabetes, immunosuppression (HIV), inserted contraceptive devices

Recurrent Vulvovaginal candidiasis = four or more episodes of symptomatic episodes in 1 year = suppressive therapy

Vulvovaginal candidiasis

TREATMENT
No need to treat sexual partners

Clotrimazole/Miconazole

Intravaginal cream
- 5-7 nights (topical as needed)

new evidence: caution with Fluconazole use during 1st trimester pregnancy → no more than 150mg tablet x1 should be used

Diflucan/Fluconazole
- x 1-3 table 1 doses

Neither Probiotics with lactobacilli nor yogurt has proven evidence in clinical trials as preventing or decreasing vaginal yeast infections

Vulvovaginal candidiasis

PATIENT EDUCATION (for BV also)

- rinse area with water
- cotton paneled, loose underpants
- loose pants/clothing
- NO soap scrubbing
- clean hands to area
- wipe front to back
- don't wear pads/pantiliners continuously
- change clothes after working out - avoid dampness
- no scented powders, sprays, esp. talc in genital region
- report to provider if hx of yeast infections with antibiotic use. Protocol treat at beginning and end of medication therapy
- talc linked to ovarian CA?
Neisseria gonorrhoeae
Gram negative (-) cocci bacteria

- 2nd most common STI
- incubation is 2-5 days; occasionally symptoms will occur up 30 days from exposure
- major cause of cervicitis and PID
- co-testing for CHL, HIV, VDRL recommended
- sites of infection are urethra, cervix, ovaries, fallopian tubes, uterus, oropharynx, and rectum

Neisseria gonorrhoeae

**SYMPTOMS**
complain of malodorous increased yellow-purulent vaginal discharge, dysuria, and menstrual irregularities

- 20-30% of women can be asymptomatic
- 20-40% of PID is caused by GC

**TESTING**
GC is reportable to State Lab/Health Department

GC is tested by:
- culture
- urine screen

*interview patient for sexual contacts info.*
Neisseria gonorrhoeae

TREATMENT

- Rocephin IM or Cefixime
- Ofloxacin
- Ciprofloxacin (500mg PO x 1 dose)

Ciprofloxacin resistance is still concerning

TOC recommended
- 4 weeks after treatment completed

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Neisseria gonorrhoeae

TREATMENT

Co-infection with CHL
Azithromycin or Doxycycline
- added to Rocephin

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Chlamydia trachomatis

- incubation period is ~7 - 21 days
i.e. ask when last sexual intercourse
Chlamydia trachomatis

**SYMPTOMS**
- women complain of vaginal discharge (usually clear), dysuria, pelvic pain, and sometimes AUB
- approx 85% of women can be *asymptomatic* which leads to easy transmission to sexual partners

**TESTING**
- CHL is reportable to State Lab/Health Department
- CHL is tested by:
  - culture
  - urine screen

**Co-infection with GC**
- 20-30% of the time women will have both STIs together

**EDUCATION**
- Doxycycline and Azithromycin (most common)
- Ofloxacin and Erythromycin are used also
- **TOC recommended**
  - 4 weeks after treatment completed

Chlamydia trachomatis
can cause PID, ectopic pregnancy, and infertility, cervicitis, salpingitis
Chlamydia trachomatis

- keep in mind both of these STIs can cause Pelvic Inflammatory Disease (PID)
- refer women with abdominal pain to upper level provider ("bent over" presentation)

Genital Herpes

- double-stranded DNA virus (HSV-1 and HSV-2) moves along afferent nerves to locate the sacral ganglion host
- both HSV-1 and HSV-2 can cause genital herpes

... then they came out with herpes, you keep that forever like luggage.
-Eddie Murphy

Genital Herpes

- oral sex with potential HSV-1 (cold sore) most common transmission
- Genital (HSV-2) transfer to mouth
Genital Herpes

TRANSMISSION (continued)

2-5 days before lesion appears, most women have "prodromal symptoms"

- burning, itching, or irritation to area of eventual "outbreak"

- after initial infection lesions may appear 2-14 days and symptoms can be severe

- "viral shedding" occurs when lesions are present but also in the absence of genital lesions. Therefore, transference to others is debated heavily and difficult to establish

Genital Herpes

SYMPTOMS

- painful lesions with vesicle-like blisters with erythem ulcerative appearing base

Severe symptoms

- present with fever, swollen (inguinal) glands, flu-like symptoms, multiple oral lesions

Genital Herpes

TESTING/DIAGNOSIS

- viral culture within 2-3 days of ulceration is best

Random blood testing for HSV-2 is not recommended due to risk of false positive
Genital Herpes

TREATMENT

Anti-virals
• Acyclovir
• Famvir
• Valacyclovir

Patient education
• ↓ stress & anxieties
• sexually responsible habits
• healthful lifestyle changes
• condom use
• handouts explaining how to prevent transmission etc. life-long infection

Genital Herpes

TREATMENT (continued)

Anti-viral medications

If continuous outbreaks or > 4 episodes per year
Suppressive regimen doses should be considered
• i.e. acyclovir 2x per day
• after ~4 months consider stopping and observe

Genital Herpes

SYMPTOMS (continued)

• multiple, *painless* shallow-appearing indurated clean based ulcers can be a chancre - syphilis

Pregnant Inmates
Pregnant Inmates

- Vaginal bleeding
- Placental Abruption
- Placenta Previa
- Emergency Childbirth

Vaginal bleeding

- brown or pink similar to end of period, that is light = spotting
- bright red blood that saturates a pad = bleeding

Vaginal bleeding

- vaginal bleeding occurring in the first trimester of pregnancy may not be signs of problems

  i.e. bleeding, hormone changes, cervical changes, an infection, or implantation of placenta

Vaginal bleeding

- however, bleeding in 2nd or 3rd trimester can be signs of complications

  Reasons: miscarriages, ectopic pregnancies, "mole" pregnancy - growth of abnormal tissue not an embryo, pelvic cavity infection, UTI, growths on cervix or STI/BV causing inflamed cervix

  Rare: uterine rupture, cancer
Placental Abruption

- occurs when the placenta is detaching from the uterine wall, partially or completely
- usually happens during last 12 weeks of pregnancy

Placental Abruption

Signs/symptoms
- vaginal bleeding, clots from the vagina, back pain, tender taunt uterus, contractions, and abdominal pain
- fetal heart rate decompensation can occur
- 10-20% of women can present without vaginal bleeding

Placental Abruption

Higher Risk women =
- women already have children, women >35, previous abruption, sickle cell disease, HTN, trauma to abdomen, and/or cocaine use
- when placental separation is >50% = acute DIC occurs and fetal demise is common and puts the woman at high risk of death

Placenta Previa

- obtain history of OB/GYN care, if known condition, obtain records and continue OB/GYN appointments
- occurs when the placental edge resides low in the uterus or partially or completely covers the cervix
- if the edge is <2cm from OS labeled a previa
Placenta Previa

- can occur at anytime but decreases with increased gestational age
- bleeding is painless and can be light → heavy
- occurrence is rare (secondary to US and OB/GYN observation)

Placenta Previa

Higher Risk women =
- women already have children, previous cesarean birth, previous surgery of the uterus, multiple fetal habitus (twins, triplets or greater)

Placenta Previa

- after initial bleeding episode, OB/GYNs will monitor fetal/maternal stability to see if supportive therapy or conservative management can prolong delivery
- Previa if "complete" (edge placenta over OS) predicates C-section delivery. Goal = 34 weeks, scheduled 36-37 weeks

Emergency birth of a baby outside of "controlled setting"

- hundreds of these births occur without assistance of medical practitioner/midwife
- unexpected births occur in cars & homes most often

Vaginal delivery is rare if fetal complications
Has anyone here ever delivered a baby?

I have...

...sort of...

...a Chow Chow Litter

I kept this one...
Overview of Key Steps in Assisting in Child Birth

1) Call for help - EMS, Security, and co-workers! especially Jail on-site practitioner (if available)

2) ask woman over-all history of pregnancy
   i.e. screening for complications, "bag of waters" ruptured

3) Place on exam table, remove clothing from below the waist

4) Visualize the vaginal area, how "dilated" is vagina, is fetus visible (head, buttocks, foot?) amniotic sac present and intact
   leave the amniotic sac alone, it will rupture on its own

5) Count time between contractions
   < 2 minutes (approx) means delivery is close

6) Check vital signs and start record of events.
   a stethoscope (or doppler) can auscultate fetal heart rate (FHT)
   Rates avg = 110-160

7) Position woman in "sitting up" position lithotomy position
   (most exam tables have stirrups) and cover her in blankets.
   Delegate someone to gather supplies

Overview of Key Steps in Assisting in Child Birth

Most important supplies include:

- gauze sponges
- sterile gomigloves
- antibacterial soap
- forceps/clamps
- sterile scissors
- towels/more blankets
- biohazard containers/bags (for soaked bloody items and placenta)
- bulb syringe (optional - clean cloth/finger sweep is fine
- IV if available

8) Wash hands and put on gloves/gown
9) The video shows the rest....
Overview of Key Steps in Assisting in Child Birth

DOC has addressed a protocol for emergency childbirth...

...it's still in the works

Overview of Key Steps in Assisting in Child Birth

- Consider having company-created or institution-created "childbirth kit" available at your jail for ALL staff to access

Like this one from Amazon $49.95 + $3.00 shipping

Source:

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and respective authors within

Thank you! Questions?