



Women's Health Literature Review

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Health Service Region 1



Lentigo maligna



"Dermatoscopic examination of the nasal lesion above revealed an asymmetric reticular pigment network with gray circles, as well as varying perifollicular hyperpigmentation. A shave biopsy was performed, and histologic exam confirmed the suspected diagnosis of lentigo maligna, also known as lentiginous melanoma on sun-damaged skin or Hutchinson melanotic freckle. Lentigo maligna is a precursor to lentigo maligna melanoma, a form of melanoma unique to older individuals with heavily sun-damaged skin that appears specifically in areas of chronic sun exposure. The

physical characteristics of lentigo maligna exposure include a large size, typically > 6mm and often several cm in diameter at the time of diagnosis; irregular borders; varied pigmentation (may include light brown, tan, dark brown, pink, or white); and a smooth surface. After five to twenty years of peripheral growth, if undetected and untreated, the lentigo lesion may grow vertically, and an invasive melanoma develops. In rare cases, transformation to invasive melanoma can occur more rapidly, even over the course of only a few months. Incidence of lentigo maligna peaks between age 65-80 years. Lentigo maligna typically starts as a tan, brown, or black macule that slowly expands peripherally over the course of many years. As it progresses, the lesion demonstrates more atypical features, such as uneven pigmentation and irregular borders. The most common sites of lentigo maligna are the head and

neck. Interestingly, lentigo maligna is more commonly seen on the left side of patients who have spent a great deal of time driving, and on the right side in those who were most often passengers in the front seat. Early surgical excision is the preferred treatment." (*The Clinical Advisor*, January 2014)



Weight, fertility, and the fertility diet

"Infertility, defined as the inability to conceive after a year of unprotected, frequent sexual intercourse, affects an estimated 15% of all couples during their reproductive years. The probability of pregnancy drops in women who are on the extremes of body mass, either underweight or obese. The good news is that losing weight improves fertility in morbidly obese women. In particular, weight loss appears to significantly improve menstrual regularity and ovulation. Weight loss brought about by bariatric surgery in morbidly obese women has been reported to improve a variety of re-

productive markers such as ovulation and pregnancy. In studies, although obesity predominates the cases of ovulatory infertility, 12% of ovulatory infertility can be attributed to low body mass. Following a fertility diet may result in a more cost-effective and less medicalized method of improving reproductive health in women with anovulatory disorders. Many cultures have in the past, and continue to in the present, retain seemingly peculiar food traditions to encourage successful conception. Altering food intake to affect fertility is not new. In the early 20th century, married

women in Cheshire England were reportedly known to eat a local 'fertility loaf' of whole wheat and wheat germ credited with promoting fertility in farm animals. If there is such thing as a fertility diet, one can reasonably suggest that anovulatory patients eat less animal protein (more from vegetable protein, such as that derived from peanut butter, peas, or lima beans), cut down on trans-unsaturated fats, and take multivitamins. Be cautious about making strong recommendations, as most of the available data comes from observational studies." (*Contemporary OB/GYN*, November 2009)



How high is high on the risks for breast cancer?

“While the risk factors for breast cancer have become fairly well known, just how much does each of them actually raise the risk? A BRCA1 or BRCA2 positive raises the lifetime risk of breast cancer 40-65%. A family history of a first degree relative with breast cancer has twice the risk of developing breast cancer compared to a woman with no family history. The more relatives with breast cancer the greater the risk as well. The risk of developing breast cancer is three to four times increased for women who have more than one first-degree relative with a history of breast cancer. Starting one’s period between the ages of 11 and 14 carries up to a 30% increase in breast cancer over one who starts their period after age 16. Breast cancer risk doubles for women who have not given birth or who did not have their first child before age 30. Women who experience menopause after age 55 have a 50% higher risk than those who experience menopause between 45 and 55. The most important risk factors unfortunately are just being female and aging.” (*The Journal for Nurse Practitioners*, June 2010)



Changes to the definition of the “Female Athlete Triad” syndrome

“The Female Athlete Triad was described as a syndrome in 1992 by the American College of Sports Medicine to reflect several clinical issues observed in female athletes. It was first described as the three intersecting components of disordered eating, amenorrhea (loss of periods), and osteoporosis. Over the past several years, the definition has evolved to more broadly define the components; low energy availability rather than disordered eating, menstrual dysfunction instead of amenorrhea, and reduced bone density in place of osteoporosis.” (*The Female Patient*, June 2012)

The cluster headache



“The cluster part of the cluster headache is the fact that these headaches tend to occur at the same time of the year and even the same time of the day. Often

cluster headaches occur in the spring and fall. Most begin between early evening and early morning, and patients often are awakened by a cluster headache during the night. Most cluster headache attacks peak between midnight and 3:00 am. Attacks can occur when the neck is rotated or flexed in specific ways; external pressure to the transverse processes of C4 or the nerve root of C2 can trigger a cluster headache. Other triggers for the cluster headache include alcohol (especially beer and red wine), histamine, nitroglycerine, carbon dioxide, certain odors, and weather changes. Eighty percent or more of cluster headache patients have a history of prolonged tobacco use, and at least 60% who do not smoke were the children of smokers. The onset of cluster headaches usually occurs between ages 20-40, and men are three to four times more likely to be affected. Cluster headaches are unilateral. The pain may be orbital or temporal. The patient may describe the pain as a hot poker in the eye. Pain peaks rapidly, usually within five to 10 minutes. The pain might radiate to the ipsi-

lateral forehead, jaw, cheek, and/or teeth. Patients appear restless and agitated, unable to lie still. They often sit holding their heads, and may pace the floor or bang their heads against the wall. A cluster headache is associated with at least one autonomic symptom such as forehead and facial sweating. Head aches may occur on one side of the head throughout one episode and the other side in subsequent episodes. Each attack can last from 15 minutes to 3 hours and can occur from every other day to eight episodes a day. The average delay in diagnosis from onset is five years or longer, limiting the patient’s access to correct treatment. Patients with cluster headaches are prone to significant physical, social, and economic disability; most patients, for example, find it difficult to work during a cluster headache period. Almost 20% of patients with cluster headaches report having lost a job because of their headaches, and about 8% are unemployed or on disability. Because of the associated impairment, the risk of suicide in this population is real. Suicidal ideation occurs in 55% of cluster headache patients.” (*Clinician Reviews*, June 2012)



Update on editor’s KE Diet



“A radically simple approach for 10 days, the KE Diet supplies your body with a very low-calorie, protein and fat-rich solution, delivered through a tiny feeding tube (about the size of a string of spaghetti) which goes through the nose directly to the stomach. There are no drugs and no surgery. The solution is delivered 24 hours a day through a small pump. One carries the pump and the solution easily and conveniently in a back pack. The solution is a proprietary mixture of proteins, fats, vitamins and other elements designed to maintain essential nutrition and health during the 10-day period, while suppressing hunger. The theory of the KE Diet is that it provides the body only with proteins and fats, and not with carbohydrates or sugars, thus forcing the body into a state of ketosis, in which the body burns its own fat. This is the same principle as some other low-carb programs, except the KE Diet, through its unique delivery method, intensifies the process and achieves dramatic results in a short period of time. **Update editor’s note:** I followed the initial 10 day regimen by an additional 5 days, two months later. The total weight loss for the 15 days was 23 pounds, and all abnormal lipid values returned to normal. A test to determine the total body fat composition lost is to follow. While this diet may not be for everyone, to lose this much weight this fast while under medical supervision was worth two weeks of inconvenience, and I have kept the weight off.



Health care specific to lesbian patients



“It is difficult to not make some assumptions associated with women who have sex with women (WSW) that are not supported by the literature. For example, HPV, believed to cause 90% of cervical dysplasia can be transmitted from female to female without a history of a male partner in either’s past. In fact, the WSW population is less likely to be screened for cervical cancer and have higher rates of abnormal pap

smears. When it comes to breast cancer, WSW have a higher risk of breast cancer than heterosexual women and for some reason are less likely to do breast self exams. From previous reports, WSW have significantly fewer pregnancies, miscarriages, and abortions and lower use of birth control pills than the heterosexual population. These variables place lesbians at a higher rate of developing ovarian cancer. Other elevated risks with WSW is a higher rate of suicide, and higher rates of heavy alcohol and drug use than the general population. A few changes in the wording of the history can indicate a more accepting environment for the patient seeking health care and fearful of judgment regarding their sexual orientation. Instead of

asking if they are married, one might ask if they have a partner or spouse and if they do presently or have had sexual relations with men, women, both or none. In order to provide competent care to the variety of sexual practices of certain populations, the clinician must have knowledge of the differences between WSW and heterosexual women. There are three symbols, if located in a providers office, that communicate to the WSW population that this provider will provide a safe environment for them. They are a pink triangle, a rainbow flag, and a blue square with a yellow equal sign.” (*The Journal for Nurse Practitioners*, June 2012)

Heart failure associated with pacemaker-induced dyssynchrony

“Patients with pacemakers are generally followed by a cardiologist once a year and are much more likely to have contact with a primary care provider than a cardiologist. Therefore, those who have contact with pacemaker patients should have at least an index of suspicion that pacemakers are not monitoring-free for the non-cardiologist. In a normal functioning heart, the SA node generates the electrical impulses that fans out and travels through the atria to the atrioventricular node (AV). The impulse is delayed momentarily at the AV node then travels rapidly down the right and left bundles of His and spreads out over the myocardium via the Purkinje fibers. The conduction system enables the atria and ventricles to contract rhythmically and synchronously. In the conduction of the paced heart, the impulses do not travel along the conduction system; the impulses are transmitted from myocardial cell to myocardial cell, which

occurs much slower than the conduction pathway. This slowed conduction of electrical impulses causes the myocardial tissue closest to the pacemaker lead to contract prior to more distant tissue. This can result in dyssynchrony, leading to a decrease in the systolic force of contractions and a decrease in ejection fraction. Therefore, providers should be cognizant of the signs and symptoms of heart failure which is the ultimate outcome of pacemaker-induced dyssynchrony. Signs and symptoms to watch for are shortness of breath, decreased exercise tolerance, and lower extremity edema. Other areas to assess are any episodes of dizziness, near syncope or syncope, heart palpitations, abdominal distention, intermittent episodes of weight gain, nocturnal diureses, and/or episodes of nocturnal dyspnea.” (*The Journal for Nurse Practitioners*, May 2012)

Experts seek new name for women’s heart disease

“Women experience heart illness quite differently than men. Currently, the focus of treatment for heart disease for women centers on obstructive coronary artery disease, however, women have less obstructive disease but higher rates of ischemia, which is defined as the inadequate flow of blood throughout the body because of constriction or blockage in blood vessels. Women with heart disease have more microvascular dysfunction, affecting the small vessels of the body, compared to men. Furthermore, women tend to experience worse outcomes than men because the focus is on obstructive heart disease. A collection of cardiologists have lobbied for a newer term for women, preferring ischemic heart disease over coronary heart disease.” (*The Journal for Nurse Practitioners*, June 2010)

Surgical Intervention for type 2 diabetes

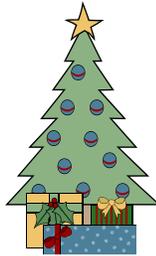
“A common international denominator for type 2 diabetes is obesity. A recent study enrolled 60 patients ages 30 to 60 years with a body mass of 35kg m or greater. All had diabetes for five or more years. Patients were randomized to surgical intervention (gastric bypass or bilio-pancreatic diversion) or medical therapy. After 2 years, no patients in the medical limb had a remission of their diabetes. However, 75% to 95% of the gastric bypass and bilio-pancreatic diversion groups, respectively, experienced remission (HbA1c, values of 6.35% and 4.95%, respectively as well). The obvious question to ask is if surgery is the universal panacea for obese patients with type 2 diabetes? The answer seems to be ‘not yet’. The studies so far have been short term and composed of small numbers. The surgical procedures may have complications, there can be psychological fallout, and micronutrient deficiencies may follow over longer periods. Remission does not equal a cure. One thing that is becoming clearer, the future of diabetes will be changing and surgery may become a viable option.” (*Consultant*, June 2012)



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Ten safe steps to terminate care of a patient

- 1) Develop a provider policy for termination made available to patients at initiation of services
- 2) Keep accurate and detailed documentation
- 3) Speak with the patient prior to a final decision or express concerns
- 4) Discuss the situation with a colleague, risk-management professional, or legal advisor
- 5) Speak directly to the patient when terminating; do not delegate
- 6) Inform staff of termination
- 7) Send a certified letter with return receipt that care will terminate in 30 days and provide a specific date
- 8) Offer interim care
- 9) Provide name and contact information for a potential alternate provider
- 10) Offer to transfer records with written permission (Clinical Advisor, June 2012)

~ Interesting Tidbits ~

~ There is a human trafficking toll free number that is manned 24 hours, seven days a week to answer calls from anywhere in the country, every day of the year: **1-888-373-7888**.

~Federal mandates that victims of sexual assault might not know are: they cannot be required to pay out of pocket for a forensic sexual assault exam, and when she has received a sexual assault exam she does not have to file charges or even talk to anyone in law enforcement. She can choose to have the evidence collected for her to have if she chooses in the future to pursue charges. Another mandate is the victim has the right to stop the sexual assault exam at anytime during the exam. Important to know is that each state has laws as to how much time the sexual assault kit collected can be kept while the victim decides whether or not to press charges. Most women are assaulted by someone they know and often it is the present or ex-partner. A reminder is that the definition of sexual assault is unwanted touching of another in a sexual manner with or without forced vaginal or anal intercourse. Less than half the time (47%), emergency room physicians prescribed emergency contraception within 72 hours of the assault, and only 4% were prescribed emergency contraception 120 hours after assault. Emergency contraception is 90% effective if given within 72 hours after an assault and 87% effective if given within 120 hours after the assault. (*The Journal for Nurse Practitioners*, June 2012)

~Interestingly, being married does not equate to greater social support when it comes to cardiovascular risk. Married women statistically have three times greater risk of death from a heart attack, compared to single women. Authors suggest that women have perplexing stressors related to managing a household. Another finding is that women tend to delay seeking treatment for an average of four hours. The number of deaths as a result of heart disease in women is rising but declining in men. This disease process is responsible for overall mortality of 49% in women. (*The Journal for Nurse Practitioners*, June 2012)

~70% of men aged 70 and above harbor microscopic prostate cancer. Most of these patients never suffer from having the disease. Indeed, the medium age of diagnosis is 67 years of age, but the medium age of death is 81. This implies that even patients with ultimately fatal prostate cancer can coexist with the disease for many years. In patients with high grade prostate cancer followed for 10 years, 25% will die of the disease, while 60% will die of competing causes. (*Panhandle Health*, Summer 2012)

More women enslaved today than in the African slave trade days



“Considering the numbers, researchers suggest there are actually twice as many people enslaved today as during the day of the African slave trade and trafficking represents the third largest source of income for organized crime. While accurate statistics on the problem are difficult to obtain, it is estimated that at least 14,500 or 17,500 individuals, mostly women, are brought into the U.S. each year, many from Asian and Latin American countries; 70% of this trafficking involves women for sex and 30% for slave labor. In fact, the U.S. is one of the largest destinations for trafficking in the world, second only to Germany. The 15,000 or so brought in do not include the 400,000 plus women and children already enslaved in the U.S. who may already be the victims of forced sex and slavery, and does not include the growing number of women who are kidnapped from neighborhoods and streets and forced into the sex trade. On a rare occasion, those entrapped girls are brought in for health care; providers may be the only individuals who interact with them. The key to rescuing these woman and teens depends on first having an index of suspicion that they might be enslaved, and second, that the provider or clinic has a plan ahead of time on what they are going to do should the situation arise. Indicators of sex-trafficking are evidence of deprivation of food and sleep, extreme stress, travel hazards, abuse, violence, torture (physical or sexual), and hazardous work, such as infection, trauma, and the sequelae of multiple forced and unsafe abortions. These problems are usually well advanced before the individual is brought in for care. There is a 24/7 hot line that can be called to report a tip, connect with anti-trafficking services in the area, or request training and technical assistance, general information, or specific anti-trafficking resources. (*The Journal for Nurse Practitioners*, June 2012)