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SPIRAL®
MANUAL

(英文原版)

Manual of Outpatient Gynecology

Fourth Edition

配英汉索引

妇科学门诊手册

Edited by
Carol S. Havens
Nancy D. Sullivan

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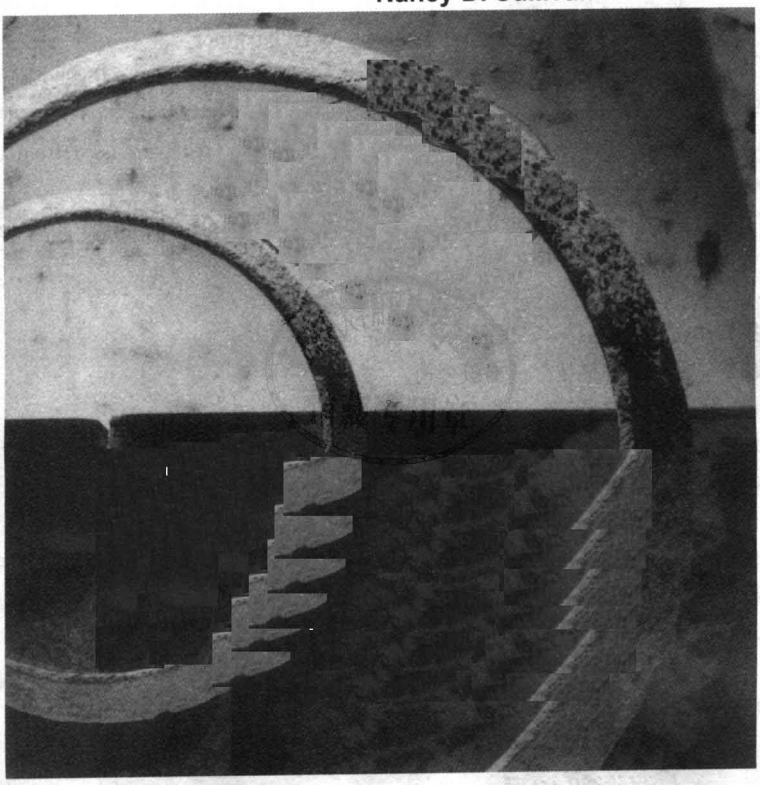

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Manual of Outpatient Gynecology
Fourth Edition

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To our mothers,
who had the stamina and courage
to raise us to be the best that we can be

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PREFACE

Manual of Outpatient Gynecology, Fourth Edition, is a practical text designed to aid in the treatment of outpatient gynecologic problems. It is meant to emphasize office diagnosis and treatment for the most frequently encountered problems and various sensitive subjects encountered in office medicine.

Women are often the health care monitors for family members and frequently ask questions regarding different age groups. Since there is a heightened interest in herbal and vitamin remedies, various "natural" treatments have been added to several chapters throughout the manual, and a chapter has been devoted to complimentary and alternative medicine. The health care maintenance chapter includes updated recommendations for health care maintenance for all age groups. Discussions of inpatient management and of most surgical therapies are beyond the scope of this book.

The *Manual* is intended for anyone treating gynecologic problems, including gynecologists, family physicians, internists, house officers, medical students, nurse practitioners, and physician assistants.

We have kept the format practical and simple. Each chapter covers a specific issue and is written in an outline format with headings that include, but are not limited to, history, physical examination, investigative procedures, and management. Some chapters have tables that can also be used for patient handouts. Each chapter also includes references for the reader who desires more comprehensive information.

C.S.H.
N.D.S.

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Our heartfelt gratitude is extended to all who have contributed their expertise and time to this edition. The contributors and editors from the third edition are indeed included in our thanks, for without them there would never have been a fourth one. We also acknowledge Jenny Kim of Lippincott Williams & Wilkins for her assistance and gentle prodding.

We personally thank Kyra and Jessica for their support and patience during this edition.

Notice: The indications and dosages of all drugs in this book have been recommended in the medical literature and conform to the practices of the general medical community. The medications described do not necessarily have specific approval by the Food and Drug Administration for use in the diseases and dosages for which they are recommended. The package insert for each drug should be consulted for use and dosage as approved by the FDA. Because standards for usage change, it is advisable to keep abreast of revised recommendations, particularly those concerning new drugs.

CONTENTS 目 录

1. VULVOVAGINITIS

Nancy D. Sullivan and Caryn Rybczynski

Vulvovaginitis is the most common of all outpatient gynecologic problems and accounts for 10% of office visits annually for the primary care provider (35). The diagnostic accuracy with patients complaining of vaginal irritation, odor, and discharge has been enhanced over the past several years by a greater understanding of bacterial vaginosis (BV). By using current knowledge and simple office laboratory methods, a precise etiologic diagnosis can be made in more than 95% of patients. These patients can be divided into five diagnostic categories, each with different management strategies. In a study of vaginal infections or discharges in 20,000 consecutive patients, BV was the most common diagnosis (33%), followed by cervicitis (20%–25%); monilial infection (20.5%); excessive, but otherwise normal, secretions (10%); *Trichomonas* (9.8%); and diagnosis undetermined (2%–5%) (10).

The approach to diagnosing the patient with vulvovaginitis consists of a careful history, pelvic examination, and microscopic examination of the vaginal fluid as well as assessment of vaginal pH and amine tests. All of these parts of the evaluation contribute to, and are essential for, a precise diagnosis.

A normal physiologic vaginal discharge consists of cervical and vaginal secretions, epithelial cells, and bacterial flora. The normal vaginal pH is 3.8 to 4.2. A physiologic vaginal discharge is usually white and odorless, and does not cause itching, burning, or other discomfort. The amount of discharge varies with the day of the menstrual cycle. The normal vaginal flora consists of primarily Lactobacillus as well as streptococci, staphylococci, diphtheroids, *Gardnerella vaginalis, E. coli,* and several anaerobic organisms. *Candida* and *Mycoplasma* species are also commonly found.

This chapter describes the evaluation and treatment of the common causes of vulvovaginitis. These are candidiasis; BV *(Gardnerella), Trichomonas,* cervicitis; chemical or irritative causes; and atrophic vulvovaginitis. Sexually transmitted diseases (STDs) such as herpes genitalis, chlamydia, and gonorrhea, are discussed in Chapter 3.

I. History. The classic presentation of vaginitis is found in fewer than 33% of cases. The discharge color, presence of pruritus, and the color of the cervix may lead to inappropriate diagnosis and therapy. **Treatment based on symptoms alone has been clearly shown to be inaccurate and should be avoided.**

The following questions should be asked of all women presenting with any vulvovaginitis complaint:

A. Current symptoms

1. Focus on changes from her personal norm.
2. **Discharge.** Most women have some degree of leukorrhea. "How is the current discharge different?"
3. **Odor**
   - **a.** Is there **any** odor?
   - **b.** Is the odor **constant**?
   - **c.** Does the odor occur **after coitus**?
4. **Pruritus**
   - **a.** Is there a **pattern** to the itching?
   - **b.** Does the itching seem to be **internal, external,** or **both**?
5. **Burning**
   - **a.** Is there burning **with urination**?
   - **b.** Does the burning occur **while urinating**?
   - **c.** Does the burning occur as the **urine touches the skin**?
6. **How long have the symptoms been occurring?**
   - **a.** What makes them better?
   - **b.** What makes them worse?

This chapter is a revision of the third edition chapter by Nancy D. Sullivan.

7. **Skin irritation or lesions**
   a. Is the skin irritated?
      (1) What areas are involved?
         (a) Vulva
         (b) Vagina
         (c) Rectum
   b. Is there a history of **sensitive** skin?
   c. Is there a history of **dry** skin?
   d. Is there any rash or sore on any part of the body?
8. **Sexual activity**
   a. Are the sexual partners male, female, or both?
   b. Are the **symptoms increased** with sexual activity?
   c. In the past year, has there been **more than one coitus** partner?
   d. Is the **sexual partner** in a **monogamous relationship** with the patient?
   e. Is there a **need** for **contraception**?
9. **Medication** and **contraceptives.** Medications, contraceptives, and barrier methods have **all been contributory causes** for vulvovaginitis, consequently, they all need to be identified.
10. **Menses history**
    a. **Date** of last menstrual period (LMP).
    b. Do the **symptoms** occur in any **relationship** to the menstrual cycle?
    c. Is the patient **pregnant**?
11. **Feminine hygiene products.** Some women use over-the-counter (OTC) sprays, perfume, or douches, or a combination thereof, regularly. If this practice is identified, it should be discouraged. These **products can be the cause of vulvovaginitis.**
12. **Recurring vulvovaginitis symptoms need to include the following questions:**
    a. Have any medications **caused itching**?
    b. Have any medications **caused burning**?
    c. What **medications have been used** for this problem? It's important to recognize that many women will have tried OTC therapies or will have been prescribed a medication after a telephone consultation only.
       (1) Miconazole (Monistat)
       (2) Terconazole (Terazol)
       (3) Ketoconazole
       (4) Clotrimazole (Gyne-Lotrimin)
       (5) Metronidazole (Flagyl)
       (6) Antibiotics
       (7) Hydrocortisone
       (8) Estrogen cream
       (9) Acyclovir (Zovirax)
       (10) Fluorouracil (5-FU) cream
       (11) Others including OTCs
    d. **Systemic diseases. Some** systemic diseases **can cause vulvovaginitis** symptoms leading the provider to potentially conclude an inaccurate diagnosis. A few of these include:
       (1) Diabetes mellitus
       (2) Acquired immunodeficiency syndrome (AIDS)
       (3) Rheumatoid arthritis
       (4) Lupus
       (5) Hodgkin's disease
       (6) Leukemia
       (7) Skin diseases such as **psoriasis** and **eczema**

II. **Physical examination** (PE). The PE must include the vulva, vagina, and cervix. On occasion, the uterus, ovaries, and rectum also need to be evaluated. When **managing difficult or recurring cases** of vulvovaginitis, the **goal of the PE shifts to identifying cutaneous lesions** (which may need biopsy); **obtaining**

vaginal secretions for further evaluation; and **investigating the possibility of obscure diagnoses,** such as rectovaginal fistula, vesicovaginal fistula, bladder leakage, and urethral diverticulum.

III. Laboratory procedures

A. Saline and potassium hydroxide (KOH) preparations generally take less than 3 minutes yet are **invaluable** in identifying what is or is not causing the vulvovaginitis complaint. If there is an excess of white blood cells (WBCs), a mixed infection must be considered.

B. Cultures of the vaginal fluids or cervix **may be necessary** to clarify the diagnosis.

C. The pH of the normal vaginal discharge is 3.8 to 4.2. An alkaline pH suggests BV or *T. vaginalis.*

IV. Vulvovaginal candidiasis (VVC), **formerly called monilia or candidiasis,** is a common fungal infection of the vulva and vagina caused by *Candida albicans, Candida tropicalis, Candida glabrata* (formerly *Torulopsis glabrata*), and *Candida parapsilosis.* Since the 1980s, the incidence of non-*C. albicans* infection has more than doubled and now accounts for more than 21% of cases.

It has been estimated that 75% of all women will have an episode of candida vaginitis at least once and as many as 40% to 50% will have recurrent infections. A small subpopulation, **approximately 5%, will have several recurrent, often intractable episodes of VVC.**

Sexual intercourse is not the means of transmission because these organisms are part of the endogenous flora in up to 50% of asymptomatic women. Environmental changes in the vagina, including the vaginal flora, result in the infection. Predisposing factors for VVC include diabetes, systemic antibiotics, pregnancy, use of oral contraceptives or corticosteroids, tight clothing, obesity, warm weather, and a decreased host immunity to *Candida* species.

A. History. The symptoms of VVC depend on the degree and location of tissue inflammation.

1. In mild cases, the most common complaint is **pruritus.**
2. As the disease progresses, **burning, soreness,** and **dyspareunia** occur.
3. **Dysuria** is a common symptom of VVC in the urethra and must be distinguished from infection of the urinary tract to avoid the inappropriate use of antibiotics.
4. **Vaginal discharge may not be present;** however, some patients describe a characteristic white curd drainage.

B. Physical examination

1. Monilial infection of the vulva and vagina may cause **erythema.**
2. **Occasionally,** excoriation from scratching and small red satellite lesions are present on the vulva.
3. If present, the curdlike discharge may be localized or may coat the entire vagina.
4. **In severe cases,** vulvar edema and tissue fissuring may occur.

C. Investigative procedures

1. A **wet-mount preparation** with saline or 10% KOH demonstrates pseudohyphae and spores in most patients (Fig. 1.1). When these are present, the diagnosis is confirmed. They may be absent, however, in a significant number of cases because non-*Albicans* species may not be readily identifiable on KOH.
2. When pseudohyphae and spores are not seen, the clinician must decide whether to treat on the basis of signs and/or symptoms or to obtain a culture.
   a. A **gonorrhea culture** can also be used as a yeast culture since *Candida* grows on Thayer-Martin medium despite the presence of nystatin.
   b. **Culture media,** such as Sabouraud's or Nickerson's, should be used. Growth is evident within 1 to 3 days.
   c. The **presence of** *C. albicans* in the **absence of clinical disease** is not diagnostic of candidal vaginitis.

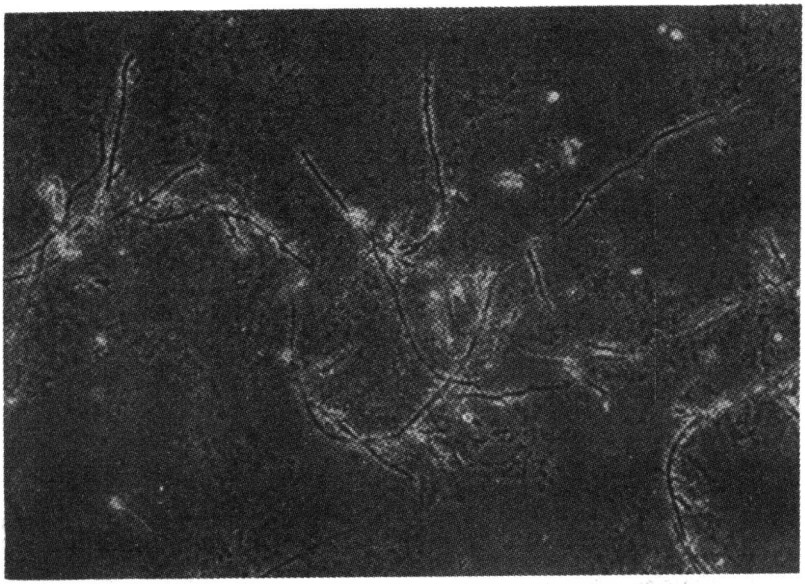

FIG. 1.1. Pseudohyphae and spores of *Candida* on wet smear. (Reproduced with permission from Fleury FJ. Adult vaginitis. *Clin Obstet Gynecol* 1981;24:407.)

D. Management. It is often helpful to classify candidiasis as uncomplicated or complicated to facilitate the selection and duration of therapy.

Uncomplicated *Candida vaginitis* is infection that occurs in a normal, healthy woman and involves symptoms that are sporadic and infrequent and not chronic or recurrent. Most often the symptoms have been present for 48 to 72 hours. In this setting, most patients do very well with a short course of therapy, regardless of whether it is topical or oral.

Complicated candidiasis represents approximately 10% of all cases and includes:

- Severe infection with severe vulvovaginal signs and symptoms including severe erythema, edema, severity pruritus, and dyspareunia.
- Recurrent disease, that is four or more episodes in the last 12 months.
- Evidence, on wet-mount KOH, of budding yeast but not hyphal elements, which increases the likelihood of *C. glabrata* or *Saccharomyces cerevisiae*, species that are less likely to respond to traditional therapy.
- An abnormal host. Most of these patients require a minimum of 7 days of therapy but may need more prolonged treatment, up to 14 days, to achieve complete resolution of symptoms.

1. **Pharmacologic treatment.** Creams have the advantage over suppositories in that they may be directly applied to the vulva. Oral medications are easy to use but can have substantial side effects and can be costly.
   a. **Miconazole** (Monistat) and **clotrimazole** (Gyne-Lotrimin) creams or suppositories are rapidly effective for monilial vulvovaginitis, when used intravaginally at bedtime. These products are now available OTC.
      (1) **In mild cases,** 3 days of treatment may be sufficient, with 7 days adequate for most cases.
      (2) **Severe cases** may require 10 to 14 days.