Transcript Details
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Lessons from an OB-GYN Practice: Facing Patient Fears Head On

Ana Maria Rosario:
Welcome to *Advance's in Women's Health* on ReachMD. I'm Ana Maria Rosario, and I recently caught up with Dr. Patricia Boatwright, who is the Women's Health Medical Director at Louis A. Weiss Memorial Hospital in Chicago, Illinois. Dr. Boatwright is going to share with us real patient cases where she saw first-hand the importance of routine gynecological appointments and how diagnostic regimens are being taught to new residents. Let's hear from Dr. Boatwright now.

Dr. Boatwright:
So a patient comes in, chief complaint, routine examination. No other history that she volunteers on the intake. And I walk in, and she is 53 years old, she is a gravitas 0, I mean she has never carried a pregnancy state. She is post-menopausal in that she has not had any bleeding for approximately six months to a year and was starting to have some hot flashes. Breast exam was normal. Abdominal exam, I palpated a mass over her umbilicus, at least, that's her belly button, two or three fingers above her belly button. I said, "So, how long have you had this tumor?" And she said, "You can feel it?" And I said, "Well, yeah," and she said, "Oh, for a while." I said, "Greater than six months?" She said, "Yes." I said, "Greater than two or three years?" She said, "Yes." I said, "Has it gotten bigger?" And she said, "Oh, yes, a little." In that her jeans had changed size and she felt that she could not exercise to keep her waistline. Well, it turned out this lady had a leiomyoma, a fibroid that was over the size of a five month pregnancy. And I said, "Well, why did you not address this prior?" and she said, "If it doesn't bother you, don't bother it." And I said, "OK. There's a problem with that. When it starts to bother you, that's a bigger problem for you." The uterus only has three ways to tell you that it doesn't feel good. It grows, it bleeds, or it hurts, or pressure. Many times, I feel that a patient will say that to me because she obviously looked pregnant at the age of 53 because she wants to be reassured that she does not have to address the problem, i.e. she's afraid. And then she will seek out people who give her that reassurance, so she does not have to address the problem. And I had not done my bimanual exam where I palpate the uterus, tubes, and ovaries that comes back to that exam under anesthesia, then I may have missed it and of course, she maybe would not have volunteered it because if it doesn't bother her, don't bother it. But it was bothering her. But she compensated for the bothersome symptoms because of the fear factor. She didn't want to address it. And she had been falsely reassured.

Brings up to the point where exam should be done. Not necessarily every year, depending on your age group and your medical history, but the gynecologist should not be skipped. And an internist, your primary care can render that gynecological exam if they have the knowledge base and the comfort level in picking up that which is abnormal. They have to be able to pick up that which is abnormal, otherwise they do the patient a disservice. I've been told and I emphasize this to your listeners, the bimanual exam is as important as that pap smear. So many patients have come in and said that they had the pap smear but the other part that I do where I palpate the uterus, tubes, and ovaries, Boatwright, no one else did that, and that is where I pick up a lot of my pathology.

But let's say this was a 53-year-old and this has come into play, and she had a uterus that was generous and some abnormal bleeding, but let's change that age from 53 to 43. Unfortunately, the residents now will go through a diagnostic regimen where they are not doing the bimanual, they rely very much on ultrasound and that's a whole other topic because ultrasound is an imaging modality using sound waves to take a picture of the pelvis. You have to rely on the technology of the soundwaves but also the interpreter of the soundwaves. And so many times, the technical part is more advanced than the interpretation part. So the radiologist doesn't pick up the pathology. Furthermore, remember, he's not interviewing the patient and she's not there to give him "that hurts on that part of the transvaginal or transabdominal exam," whereas I am. Because the residents now are not as keen on examining the patient and using their hands to pick up the pathology, they rely on that ultrasound. And based on that ultrasound they will do protocols that don't necessarily match that which is being presented to them. Because they did not train their hands to do the exam under anesthesia. She's 43, the ultrasound is reassuring, she's having some bleeding, she doesn't have any major medical problems, let's try to control her with birth control pills or hormonal manipulation. As opposed to examining her and picking up the fact that she is tender by exam even though subjectively, she didn't complain of any pain and therefore, there is some uterine pathology that would not be conducive to being handled with birth control pills. And so that goes into, and insurances are really trying to dictate to us what we do, you go from A to B, A is some routine

labs, B is the ultrasound, C is the birth control pill, if it fails, D is finally sampling the uterus and then depending on what the pathology shows, go from there. They have to go through all that. Whereas an exam could've gone from A and B straight to C or D.

Ana Maria Rosario:
You've been listening to *Advances in Women's Health*. To revisit any of this discussion, and to here more of my conversations with Dr. Patricia Boatwright, visit ReachMD.com, where you can Be Part of the Knowledge. Thanks for listening.

Dr. Boatwright:

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