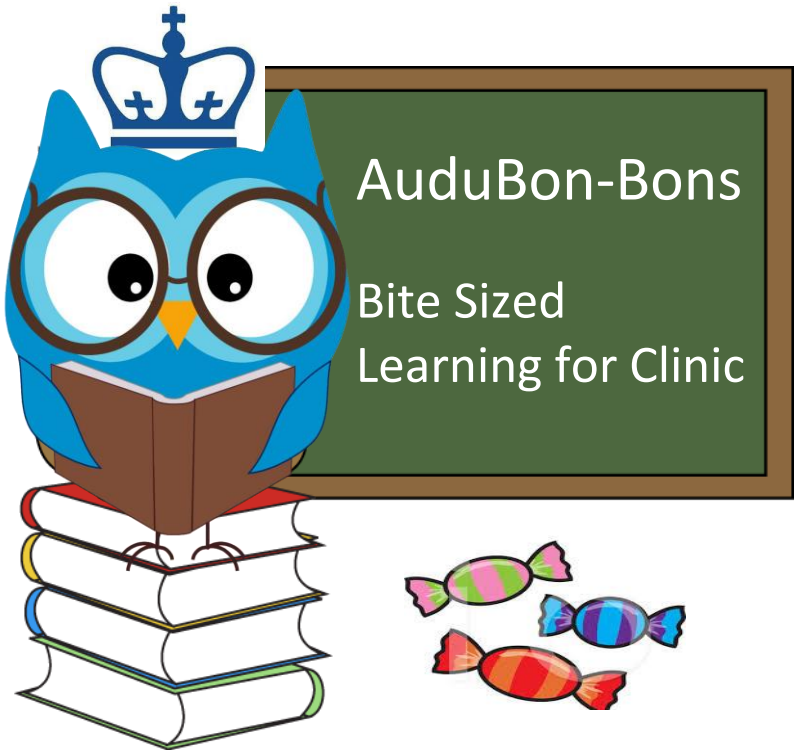
PERIODIC HEALTH ASSESSMENT: 65+ YEARS



Week 89

Prepared by: **Stephanie Warsheski, MD**

Reading Assignment:
Download the **WPSI 2020 Well-Women Chart** for your reference

Download CDC Vaccine Schedule app

LEARNING OBJECTIVES

- To understand the importance of periodic health assessments in women
- To provide a general overview of women's preventative services and care, particularly in the 65+ year old women
- To review when it is appropriate to discontinue preventative services

CASE VIGNETTE

- Ms. Dulce Anciana, a 69 y.o. woman, presents to GYN clinic requesting a pap smear. She was recently seen by her PCP and referred to you for care.

GOALS

- To provide preventative health services
- To provide counseling regarding maintenance of a healthy lifestyle
- To aid women in minimizing health risks

FOCUSED HISTORY

What elements of this patient's history are most relevant?

- **Reason for visit**
- **Pertinent symptoms**
  - Menopausal symptoms
  - Postmenopausal bleeding
  - Vaginal discharge
  - Pain
  - Pelvic prolapse
  - Urinary or fecal incontinence

FOCUSED HISTORY

- OBHx: NSVD x 2
- GYNHx: Postmenopausal since 53 years old, denies PMB
  Denies h/o abnormal paps, STIs, fibroids, cysts
  SA with 1 partner only – husband
- PMHx: HTN, HLD, depression
- PSHx: LSC appendectomy, PP BTL

FOCUSED HISTORY

- Meds: HCTZ, atorvastatin, LDA
- All: NKDA
- SocHx: Lives with her husband, denies IPV
  Retired
  Denies use of alcohol, tobacco or illicit drugs
  Exercises occasionally and cooks most meals at home
- FamHx: Mother died of breast cancer in 70's, Father with T2DM

PERTINENT PHYSICAL EXAM FINDINGS

What elements of the patient's physical exam are most important?

- Vitals: BP 149/86, 178lbs, 5'4", BMI 31
- HEENT: No adenopathy, normal thyroid
- Breast: Symmetric, non-tender, no masses, no skin changes, no nipple changes or discharge, no LN
- Abd: Obese, non-distended, soft, nontender
- Pelvic:
  - Vulva: NEFG, atrophic, no lesions
  - Vagina: Atrophic, no discharge
  - Cervix: Parous os, no lesions, no discharge, no CMT
  - Uterus: Small, AV, non-tender
  - Adnexa: No masses, non-tender
  - Rectovaginal: No masses or tenderness

LABORATORY AND OTHER TESTS

Periodic

- Cervical cancer screening: as per ASCCP guidelines
- Mammography: age 40 – 75, annually*
- Bone mineral density screening: age 65* - 80
- Colorectal cancer screening: age 50* - 75, every 1-10 years

- Diabetes testing: age 40 – 70, every 3 years
- Hepatitis C virus testing: at least once between 18 – 79 years
- Lipid profile: age 45 – 75, every 5 years

CERVICAL CANCER SCREENING

Table 1. Screening Methods for Cervical Cancer for the General Population: Joint Recommendations of the American Cancer Society, the American Society for Colposcopy and Cervical Pathology, and the American Society for Clinical Pathology*

Population	Recommended Screening Method	Comment
Women younger than 21 years	No screening	
Women aged 21–29 years	Cytology alone every 3 years	
Women aged 30–65 years	Human papillomavirus and cytology cotesting (preferred) every 5 years Cytology alone (acceptable) every 3 years	Screening by HPV testing alone is not recommended*
Women older than 65 years	No screening is necessary after adequate negative prior screening results	Women with a history of CIN 2, CIN 3, or adenocarcinoma in situ should continue routine age-based screening for a total of 20 years after spontaneous regression or appropriate management of CIN 2, CIN 3, or adenocarcinoma in situ
Women who underwent total hysterectomy	No screening is necessary	Applies to women without a cervix and without a history of CIN 2, CIN 3, adenocarcinoma in situ, or cancer in the past 20 years
Women vaccinated against HPV	Follow age-specific recommendations (same as unvaccinated women)	

Abbreviations: CIN, cervical intraepithelial neoplasia; HPV, human papillomavirus.

*After the Joint Recommendations were published, a test for screening with HPV testing alone was approved by the U.S. Food and Drug Administration. Gynecologic care providers using this test should follow the interim guidance developed by the American Society for Colposcopy and Cervical Pathology and the Society for Gynecologic Oncology (Huh WK, Ault KA, Chelmow D, Davey DD, Goulart RA, Garcia FA, et al. Use of primary high-risk human papillomavirus testing for cervical cancer screening: interim clinical guidance. Obstet Gynecol 2015;125:330–7.).

Modified from Saslow D, Solomon D, Lawson HW, Killackey M, Kulasingam SL, Cain J, et al. American Cancer Society, American Society for Colposcopy and Cervical Pathology, and American Society for Clinical Pathology screening guidelines for the prevention and early detection of cervical cancer. ACS-ASCCP-ASCP Cervical Cancer Guideline Committee. CA Cancer J Clin 2012;62:147–72.

CERVICAL CANCER SCREENING

In which patient populations should cervical cancer screening continue past age 65?

- Women with a history of CIN 2, CIN 3, or adenocarcinoma in situ should continue screening for a total of *20 years after spontaneous regression or appropriate management* of CIN 2, CIN 3, or adenocarcinoma in situ
- Women infected with HIV
- Women who are immunocompromised (such as those who have received solid organ transplants)
- Women who were exposed to diethylstilbestrol in utero

Table 1. Recommendations for Breast Cancer Screening in Average-Risk Women

	American College of Obstetricians and Gynecologists	U.S. Preventive Services Task Force	American Cancer Society	National Comprehensive Cancer Network
Clinical breast examination	May be offered* every 1–3 years for women aged 25–39 years and annually for women 40 years and older.	Insufficient evidence to recommend for or against.†	Does not recommend‡	Recommend every 1–3 years for women aged 25–39 years. Recommend annually for women 40 years and older.
Mammography initiation age	Offer starting at age 40 years.§ Initiate at ages 40–49 years after counseling, if patient desires. Recommend by no later than age 50 years if patient has not already initiated.	Recommend at age 50 years.‖ Age 40–49 years: The decision to start screening mammography in women before age 50 years should be an individual one.¶	Offer at ages 40–45 years.† Recommend at age 45 years.#	Recommend at age 40 years.
Mammography screening interval	Annual or biennial§	Biennial	Annual for women aged 40–54 years‡ Biennial with the option to continue annual screening for women 55 years or older‡	Annual
Mammography stop age	Continue until age 75 years. Beyond age 75 years, the decision to discontinue should be based on a shared decision-making process that includes a discussion of the woman's health status and longevity.	The current evidence is insufficient to assess the balance of benefits and harms of screening mammography in women 75 years and older.†	When life expectancy is less than 10 years‡	When severe comorbidities limit life expectancy to 10 years or less

*Offer in the context of a shared, informed decision-making approach that recognizes the uncertainty of additional benefits and harms of clinical breast examination beyond screening mammography.

†Category I recommendation

‡Qualified recommendation

§Decision between options to be made through shared decision making after appropriate counseling

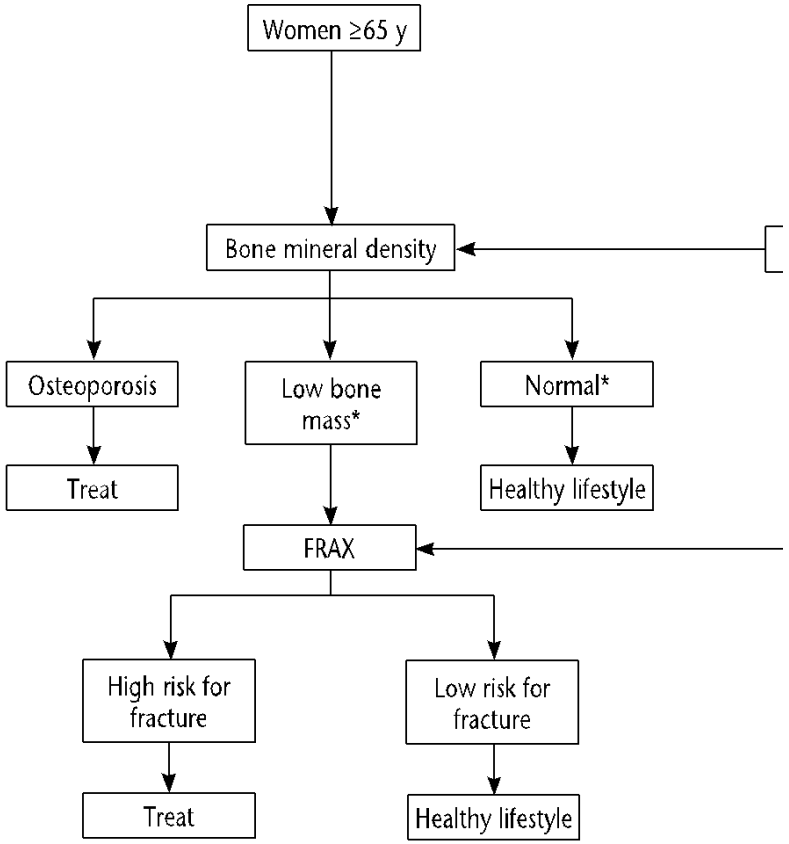
‖Category B recommendation

¶Category C recommendation. The Task Force notes that "Women who place a higher value on the potential benefit than the potential harms may choose to begin screening between the ages of 40 and 49 years."

#Strong recommendation

Data from National Comprehensive Cancer Network. Breast cancer screening and diagnosis. Version 1.2016; Oeffinger KC, Fontham ET, Etzioni R, Herzig A, Michaelson JS, Shih YC, et al. Breast cancer screening for women at average risk: 2015 guideline update from the American Cancer Society [published erratum appears in JAMA 2016;315:1406]. JAMA 2015;314:1599–614; *and* Siu AL. Screening for breast cancer: U.S. Preventive Services Task Force recommendation statement. U.S. Preventive Services Task Force [published erratum appears in Ann Intern Med 2016;164:448]. Ann Intern Med 2016;164:279–96.

BONE MINERAL DENISTY SCREENING



*Fragility fracture is an indication for treatment despite lack of osteoporosis on DXA

Fig. 2. Screening and treating postmenopausal women for fracture prevention. (Screening and treating premenopausal women is generally restricted to women who have diseases, conditions, or medication use known to increase risk of fractures).
Abbreviations: FRAX, fracture risk assessment tool; DXA, dual-energy X-ray absorptiometry.

Table 1. Diagnosing Osteoporosis Using Bone Densitometry Criteria Developed by the World Health Organization

Category	T Score*
Normal	Greater than or equal to –1.0
Low Bone Mass (osteopenia)	Less than –1 to greater than –2.5
Osteoporosis	Less than or equal to –2.5

*T-score is the number of standard deviations above or below the mean average bone density value for young adult women.

COLORECTAL CANCER SCREENING

Colorectal Cancer Screening	
Rationale: Colorectal cancer is most common among adults over age 50 years and early detection with screening can reduce mortality. **USPSTF Recommendation:** Screen for colorectal cancer starting at age 50 years and continuing until age 75 years.	
Ages and Frequency	50 to 75 years: frequency varies by method
Clinical Practice	Screening methods include gFOBT (guaiac-based fecal occult blood test), FIT (fecal immunochemical test), or FIT-DNA (multitargeted stool DNA test) every 1-2 years; flexible sigmoidoscopy or computed tomography (CT) colonography every 5 years; and colonoscopy every 10 years. The decision to screen for colorectal cancer in adults aged 76 to 85 years should be an individual one that considers the patient's overall health and prior screening history.
Risk Assessment	Black women and those with a family history of colorectal cancer (a first-degree relative with early-onset colorectal cancer or multiple first-degree relatives with the disease) have increased risks for colorectal cancer and may consider screening at earlier ages.
References	• Bibbins-Domingo K, Grossman DC, Curry SJ, et al. Screening for colorectal cancer: US Preventive Services Task Force recommendation statement. *JAMA*. 2016; 315(23):2564-75. doi: 10.1001/jama.2016.5989. PMID: 27304597.

EVALUATION AND COUNSELING

Fitness and nutrition

- Physical activity
- Fall prevention through exercise intervention
- Dietary/nutritional assessment
- Calcium and Vitamin D intake

Table 4. Institute of Medicine Recommended Dietary Allowances for Calcium and Vitamin D ⇦

Age (yr)	Calcium Recommended Dietary Allowance (mg/day)	Vitamin D Recommended Dietary Allowance (international units/day)
9–18	1,300	600
19–50	1,000	600
51–70	1,200	600
71 and older	1,200	800

Data from Institute of Medicine. Dietary reference intakes: calcium, vitamin D. Washington, DC: National Academies Press; 2011.

Box 3. Fall Prevention Measures ⇦

Lighting

Provide accessible lighting for each part of the home

Use night-lights

Floors

Remove throw rugs or secure them to the floor

Remove all clutter from the floor

Move cords and cables away from traffic path

Use nonskid wax

Storage

Store items at a height that does not require a step stool to reach

Bathroom

Install safety grab bars in bath and shower

Apply nonskid strips to bath and shower floor

Indoors and Outdoor Stairs

Install handrails for the entire length of the stairs

Provide adequate lighting

Add nonskid treads or secure carpet indoors

EVALUATION AND COUNSELING

Sexuality

- Sexual function
- High-risk behaviors
- STIs and barrier contraception

Psychosocial

- Intimate partner violence
- Anxiety and depression
- Sleep disorders

Cardiovascular risk factors

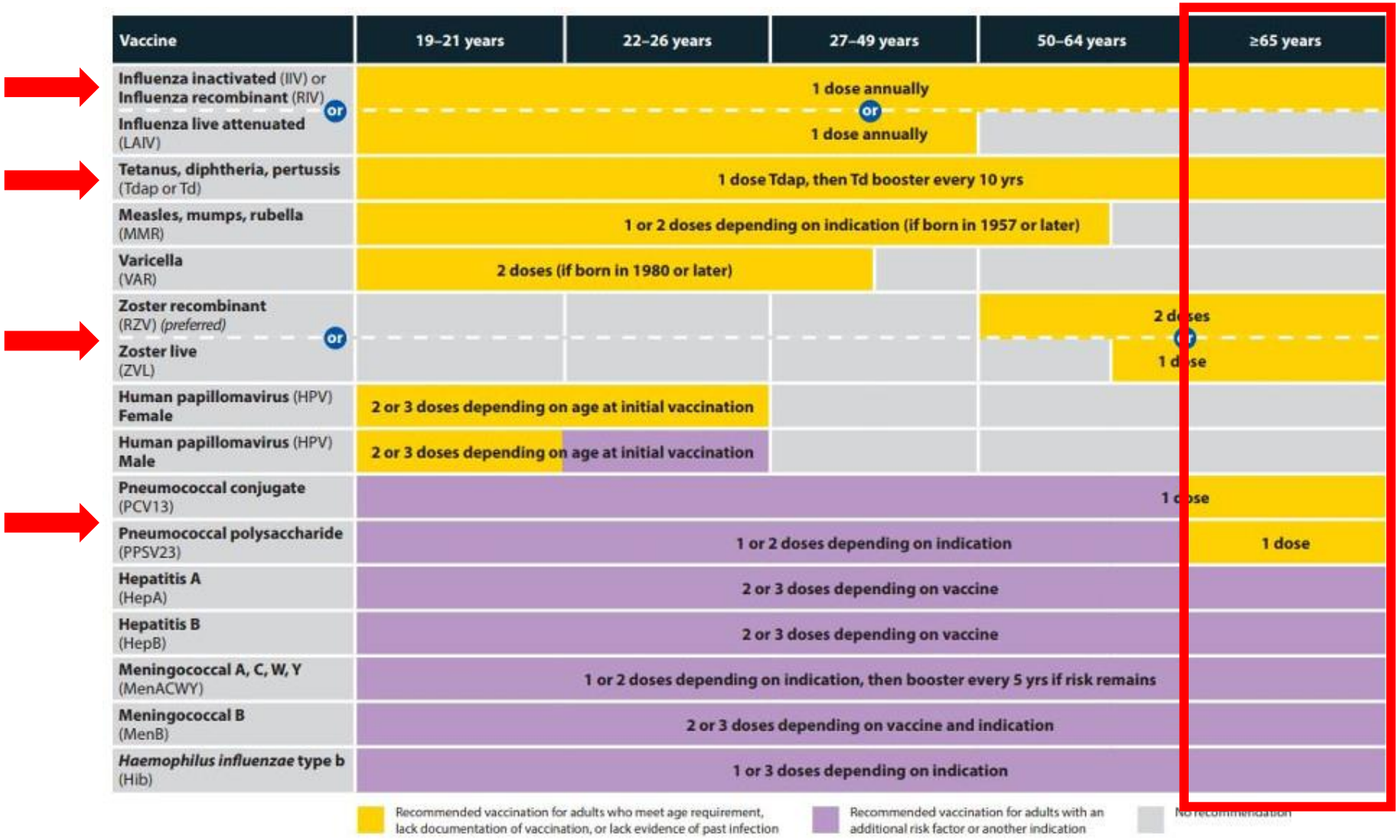
- Family hx

EVALUATION AND COUNSELING

Health/Risk Assessment

- ASA prophylaxis
- Breast self-awareness
- Chemoprophylaxis for breast cancer (HR women)
- HRT
- Hygiene (including dental)
- Injury prevention (exercise, firearms, hearing, recreational hazards, safe driving practices)
- Suicide
- Tobacco, alcohol, other drug use

IMMUNIZATIONS



Vaccine	19–21 years	22–26 years	27–49 years	50–64 years	≥65 years
Influenza inactivated (IIV) or **Influenza recombinant** (RIV)	1 dose annually				
or					
Influenza live attenuated (LAIV)	1 dose annually				
Tetanus, diphtheria, pertussis (Tdap or Td)	1 dose Tdap, then Td booster every 10 yrs				
Measles, mumps, rubella (MMR)	1 or 2 doses depending on indication (if born in 1957 or later)				
Varicella (VAR)	2 doses (if born in 1980 or later)				
Zoster recombinant (RZV) *(preferred)*				2 doses	
or				or	
Zoster live (ZVL)				1 dose	
Human papillomavirus (HPV) **Female**	2 or 3 doses depending on age at initial vaccination				
Human papillomavirus (HPV) **Male**	2 or 3 doses depending on age at initial vaccination				
Pneumococcal conjugate (PCV13)	1 dose				
Pneumococcal polysaccharide (PPSV23)	1 or 2 doses depending on indication				1 dose
Hepatitis A (HepA)	2 or 3 doses depending on vaccine				
Hepatitis B (HepB)	2 or 3 doses depending on vaccine				
Meningococcal A, C, W, Y (MenACWY)	1 or 2 doses depending on indication, then booster every 5 yrs if risk remains				
Meningococcal B (MenB)	2 or 3 doses depending on vaccine and indication				
***Haemophilus influenzae* type b** (Hib)	1 or 3 doses depending on indication				

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended vaccination for adults with an additional risk factor or another indication

No recommendation

KEY:

- ● Recommended by the USPSTF (A or B rating), WPSI, or Bright Futures
- ○ Recommended for selected groups

WPSI

Women's Preventive Services Initiative

PREVENTION SERVICES	65-75	>75
GENERAL HEALTH		
Alcohol use screening & counseling	●	●
Anxiety screening	●	●
Aspirin to prevent CVD & CRC[1]		
Blood pressure screening	●	●
Contraceptive counseling & methods		
Depression screening	●	●
Diabetes screening[2]	○	○
Folic acid supplementation[3]		
Healthy diet & activity counseling[4]	○	○
Interpersonal violence screening	●	●
Lipid screening[5]	●	
Obesity screening & counseling	●	●
Osteoporosis screening[6]	●	●
Fall prevention	●	●
Statin use to prevent CVD[7]	○	
Substance use assessment		
Tobacco screening & counseling	●	●
Urinary incontinence screening[8]	●	●

PREVENTION SERVICES	65-75	>75
INFECTIOUS DISEASES		
Gonorrhea & chlamydia screening[9]	○	○
Hepatitis B screening[10]	○	○
Hepatitis C screening (at least once)[11]	●	● <79
HIV preexposure prophylaxis[12]	○	○
HIV risk assessment	●	●
HIV screening (at least once)	○	○
Immunizations[b]	●	●
STI prevention counseling[13]	○	○
Syphilis screening[14]	○	○
Tuberculosis screening[15]	○	○
CANCER		
Breast cancer screening[16]	●	○
Cervical cancer screening	● ≤65	
Colorectal cancer screening	●	
Lung cancer screening[17]	○	○ 55-80
Medications to reduce breast cancer risk[18]	○	○
Risk assessment for *BRCA 1/2* testing	●	●
Skin cancer counseling[19]		

MEMBERS OF THE ADVISORY PANEL SUPPORT THE WPSI

AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

ACP
American College of Physicians
Leading Internal Medicine, Improving Lives

NPWH
NURSE PRACTITIONERS IN WOMEN'S HEALTH
Caring for Women

SOCIAL DETERMINANTS OF HEALTH

Cost as a barrier to services and visits

- States and health insurance plans in both the public and private sectors vary widely in the preventive services they cover
- Although preventive services are covered at no cost under the ACA, insurance plans are allowed to require copays for office visits
- Increased health care costs and little to no gain in income in recent years are threatening the health and financial status of women
  - In 2010, 44% of women vs 35% of men reported difficulty in paying medical bills or were paying off medical debt
  - 1/3 of women vs < 1/4 of men stated they did not visit a doctor when faced with a medical problem due to cost
- Less than 50% of those 65 years and older are up to date on preventative health services

Increasing use of preventive services by adults should be a key public health initiative given the rapid aging of the US population

EPIC .PHRASE

BBon65PeriodicHealthAssessment

Description: 65+ yo periodic health assessment evaluation/ counseling

A comprehensive health assessment was performed including a physical exam and detailed medical history including but not limited to fitness and nutrition, sexual history, psychosocial history, cardiovascular risk factor, and health/risk assessment. Physical findings, diagnosis, preventive health services and treatment options, if needed, were discussed with the patient. A referral was given for screening mammography, bone mineral density and colorectal cancer if not up to date. Additionally, timing of discontinuation of such screening services were discussed.

CODING AND BILLING

Diagnostic Codes (ICD-10)

- Z.01.419 Encounter for well women exam
- Z12.31 Encounter for screening mammogram for malignant neoplasm of breast

Procedure Codes (CPT)

- 99203 Office/outpt visit of a new pt with 3 key components (detailed history, detailed examination, medical decision making of low complexity), counseling, typically 30 minutes spent face-to-face
- 99204 Office/outpt visit of a new pt with 3 key components (comprehensive history, comprehensive examination, medical decision making of moderate complexity), counseling, typically 45 minutes spent face-to-face
- 99397 Periodic comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; 65 years and older

EVIDENCE

References

- Breast cancer risk assessment and screening in average-risk women. Practice Bulletin No. 179. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017;130e1-16.
- CDC Adult Immunization Schedule. https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html (Accessed May 31, 2019).
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