The Annual Pelvic Examination: Preventive Time Not Well Spent
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In today’s clinical environment, primary care physicians need to make the best use of their limited time to deal effectively with patients’ medical concerns, address preventive care, and nurture the doctor-patient relationship. It has been suggested that to address every preventive service recommended by the U.S. Preventive Services Task Force (USPSTF), a typical physician with a standard patient panel would need to spend 7.4 hours per working day providing these services.1 Consequently, when considering the health maintenance examination, we must think carefully about which tasks are supported by evidence and which are being performed merely out of habit.

In this issue, Dr. Riley and colleagues review evidence-based components of the female health maintenance examination.2 Despite the lack of evidence of benefit in asymptomatic women, the American College of Obstetricians and Gynecologists (ACOG) recently advised that women 21 years and older undergo annual pelvic examinations.3 Pelvic examinations are clearly warranted before pelvic procedures (e.g., endometrial biopsy) and when patients present with menstrual problems, pelvic pain, vaginal discharge, or other symptoms. However, ACOG’s committee opinion report on the well-woman examination does not provide clear reasons to perform a pelvic examination in women who have no symptoms and for whom cervical cytology is not indicated; the report states only that this recommendation is based on expert opinion.3

A 2011 study of U.S. primary care physicians and obstetricians/gynecologists found that physicians perform routine pelvic examinations for the following reasons: (1) to screen for ovarian cancer, other gynecologic cancers, and sexually transmitted infections; (2) as a requirement for starting hormonal contraceptives; or (3) simply because they consider it part of a well-woman examination.4

A number of factors make these reasons insufficient to warrant annual pelvic examinations. First, current methods of ovarian cancer screening do not reduce mortality, have high false-positive rates, and lead to harms from subsequent invasive diagnostic procedures.5 Therefore, the USPSTF recommends against screening for ovarian cancer.6

With regard to cervical cancer screening, ACOG updated its guidelines in 2012 to recommend Papanicolaou testing every three years with cytology alone for women 21 to 65 years of age, with the option for human papillomavirus and cytology co-testing every five years for women 30 to 65 years of age.7 Similar statements from the USPSTF8 and from the American Cancer Society/American Society for Colposcopy and Cervical Pathology/American Society for Clinical Pathology9 agree that annual cervical cytology sampling increases false-positive rates without detecting clinically significant pathology. Consequently, annual pelvic examinations are not necessary for cervical cancer screening.

Meanwhile, urine-based nucleic acid amplification allows asymptomatic women to be screened for sexually transmitted infections without the need for a pelvic examination.9 Additionally, ACOG has recognized that pelvic examinations are not necessary before initiation of contraceptives.10 If physicians require this examination before dispensing contraceptives, it could put women at risk of adverse outcomes if such an obstacle led to an unintended pregnancy.10 Taking into account the time required for the patient to undress, the time to obtain the necessary equipment, and the time to perform the procedure, a screening pelvic examination can conservatively add an extra 10 minutes to an office encounter. In...
addition, because many physicians also require a nurse or medical assistant in the room during this examination, there is an opportunity cost associated with the other work that could have been done by the support staff during this time (e.g., stocking supply cabinets, performing immunizations, making phone calls to patients). Given the lack of evidence to support annual pelvic examinations, it would be better for patients if we spend that time addressing screening, counseling, and other preventive services for which strong evidence exists.

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