Editorials

The Annual Pelvic Examination: Preventive Time Not Well Spent

GIANG T. NGUYEN, MD, MPH, MSCE, FAAFP, and PETER F. CRONHOLM, MD, MSCE, FAAFP, *University of Pennsylvania Perelman School of Medicine, Philadelphia, Pennsylvania*

▶ **See related article on page 30.**

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 USPSTF[8] and from the American Cancer Society/American Society for Colposcopy and Cervical Pathology/American Society for Clinical Pathology[9] 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.[3] Additionally, ACOG has recognized that pelvic examinations are not necessary before initiation of contraceptives.[3] 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.

Address correspondence to Giang T. Nguyen, MD, MPH, MSCE, FAAFP, at Giang.Nguyen@uphs.upenn.edu. Reprints are not available from the authors.

Author disclosure: No relevant financial affiliations to disclose.

REFERENCES

1. Yarnall KS, Pollak KI, Østbye T, Krause KM, Michener JL. Primary care: is there enough time for prevention? *Am J Public Health.* 2003;93(4):635-641.
2. Riley M, Dobson M, Jones E, Kirst N. Health maintenance in women. *Am Fam Physician.* 2013;87(1):30-37.
3. Committee on Gynecologic Practice. Committee opinion no. 534: well-woman visit. *Obstet Gynecol.* 2012; 120(2 pt 1):421-424.
4. Stormo AR, Hawkins NA, Cooper CP, Saraiya M. The pelvic examination as a screening tool: practices of US physicians. *Arch Intern Med.* 2011;171(22):2053-2054.
5. Buys SS, Partridge E, Black A, et al.; PLCO Project Team. Effect of screening on ovarian cancer mortality: the Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Randomized Controlled Trial. *JAMA.* 2011; 305(22):2295-2303.
6. Moyer VA, U.S. Preventive Services Task Force. Screening for ovarian cancer: U.S. Preventive Services Task Force reaffirmation recommendation statement [published ahead of print September 11, 2012]. *Ann Intern Med.* http://annals.org/article.aspx?articleid=1357339. Accessed August 21, 2012.
7. Screening for cervical cancer. *Obstet Gynecol.* 2012;120(5):1222-1238.
8. Moyer VA. Screening for cervical cancer: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med.* 2012;156(12):880-891.
9. Saslow D, Solomon D, Lawson HW, 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. *CA Cancer J Clin.* 2012;62(3):147-172.
10. Sawaya GF. Pelvic examinations in asymptomatic women: tipping a sacred cow. *Arch Intern Med.* 2011; 171(22):2054-2055. ■

AFP Directory

Article proposals—Contact Jay Siwek, MD, editor (e-mail: afpjournal@aafp.org).

Other editorial questions—Call 913-906-6205 or send a fax to 913-906-6086. Use the list below to find the person who can best help you:

- **Reader feedback**—Contact Joyce A. Merriman, executive editor (e-mail: afpedit@aafp.org). For letters to the editor, follow the instructions on the first page of "Letters to the Editor" in each issue or in the Authors' Guide at http://www.aafp.org/afp/authors.
- **Delivery problems, back issues**—Contact the circulation department (800-274-2237; e-mail: afpcirc@aafp.org).
- **Subscriptions, address changes**—Refer to the ordering information on the first page of the table of contents, in the left-hand margin. For address changes: submit the change of address form provided in this issue (refer to the table of contents listing for the location of the form).
- **Permission to reuse material from *AFP:***

  Academic use, general photocopying, electronic use—See www.copyright.com and enter ISSN 0002-838X in the search box; or contact the Copyright Clearance Center (info@copyright.com; 978-750-8400; fax: 978-646-8700).

  Bulk reprints, e-prints—Contact Beth Ann Rocheleau, Sheridan Reprints (brocheleau@rockwaterinc.com; 803-359-4578).

  Other requests—Contact AAFP intellectual property coordinator (copyrights@aafp.org).

Display advertising—Contact John Molluso, director of advertising sales (e-mail: jmolluso@aafp.org), or Mickey Cotter, national account manager (e-mail: mcotter@aafp.org); telephone: 201-288-4440; fax: 201-288-4914.

Classified information—Contact Russell Johns Associates, LLC (telephone: 800-237-7027; fax: 727-445-9380; e-mail: afpinfo@russelljohns.com).

Editorial Policies

The purpose of *AFP* is to serve the medical profession and provide continuing medical education (CME). The information and opinions presented in *AFP* reflect the views of the authors, not those of the journal or the American Academy of Family Physicians, unless so stated. Advertising is accepted only if judged to be in harmony with the purpose of the journal; however, *AFP* reserves the right to reject any advertising at its sole discretion. Acceptance does not constitute endorsement by *AFP* or the American Academy of Family Physicians of a particular policy, product, procedure, or advertorial.

It is the policy of the American Academy of Family Physicians that all individuals in a position to affect the content of a CME activity disclose relationships that they or their spouse/partner have with commercial entities. Further, should any such relationship be determined to be in possible conflict of interest as it relates to the individual's proposed role in the CME activity, the conflicts of interest must be resolved before confirmation of the individual's participation. We inform readers of any pertinent relationships disclosed. A disclosure statement is published at the end of relevant articles. The medical and professional editors of *AFP* have disclosed all relationships with commercial interests. There are no relevant conflicts of interest to disclose.

AFP publishes trade names of drugs for the readers' convenience only; published names are based on what is currently available. This does not imply endorsement of any product by *AFP* or the American Academy of Family Physicians.

CME Objectives

1. To provide updates on the diagnosis and treatment of clinical conditions managed by family physicians.
2. To provide reference citations to support statements referring to clinical studies, new information, controversial material, specific quantitative data, and any other information not generally found in reference textbooks on the subject.
3. To provide balanced discussions of the strengths and weaknesses of diagnostic and treatment strategies (controversial or speculative material is identified).
4. To provide evidence-based guidelines or consensus viewpoint in preference to personal opinion.