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

COMMITTEE OPINION

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Committee on Gynecologic Practice

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Well-Woman Visit

Abstract: The annual health assessment ("annual examination") is a fundamental part of medical care and is valuable in promoting prevention practices, recognizing risk factors for disease, identifying medical problems, and establishing the clinician–patient relationship. The annual health assessment should include screening, evaluation and counseling, and immunizations based on age and risk factors. The interval for specific individual services and the scope of services provided may vary in different ambulatory care settings. The performance of a physical examination is a key part of an annual health assessment visit, and the components of that examination may vary depending on the patient's age, risk factors, and physician preference. The American College of Obstetricians and Gynecologists explains the need for annual assessments and provides guidelines regarding some important elements of the annual examination; specifically, when to perform pelvic examinations in asymptomatic women, including when to start internal pelvic and speculum examinations, and when to initiate formal clinical breast examinations.

The annual health assessment ("annual examination") is a fundamental part of medical care and is valuable in promoting prevention practices, recognizing risk factors for disease, identifying medical problems, and establishing the clinician–patient relationship (1). New recommendations and improving technologies continue to influence guidelines and the necessary components of the annual health assessment of women. The purpose of this Committee Opinion is to explain the need for annual assessments and to provide guidelines regarding some important elements of the annual examination; specifically, when to perform pelvic examinations in asymptomatic women, including when to start internal pelvic and speculum examinations, and when to initiate formal clinical breast examinations. Recommendations regarding the role of pelvic examination in the evaluation of symptoms are published elsewhere (2).

The Importance of the Annual Visit

Obstetrician–gynecologists have a tradition of providing preventive care to women. An annual visit provides an excellent opportunity to counsel patients about maintaining a healthy lifestyle and minimizing health risks. The annual health assessment should include screening, evaluation and counseling, and immunizations based on age and risk factors. The interval for specific individual services and the scope of services provided may vary in different ambulatory care settings. The performance of a physical examination is a key part of an annual visit, and the components of that examination may vary depending on the patient's age, risk factors, and physician preference. In general, the physical examination will include obtaining standard vital signs, determining body mass index, palpating the abdomen and inguinal lymph nodes, and making an assessment of the patient's overall health. Many, but not all, women will have a pelvic examination and a clinical breast examination as a part of the physical examination. Information on these core elements of the physical examination is provided in the following sections. The American College of Obstetricians and Gynecologists (the College) has comprehensive recommendations and resources for the annual health assessment of women available online at www.acog.org/wellwoman.

Pelvic Examination

The pelvic examination includes three elements: 1) inspection of the external genitalia, urethral meatus, vaginal introitus, and perianal region (external examination); 2) speculum examination of the vagina and cervix; and 3) bimanual examination of the uterus, cervix, and adnexa

(the latter two elements constitute the internal examination). When indicated, a rectovaginal examination also should be performed.

Annual pelvic examination of patients 21 years of age or older is recommended by the College. At this time, this recommendation is based on expert opinion, and limitations of the internal pelvic examination should be recognized. Studies have shown that the bimanual examination is better at evaluating the uterus than the adnexa and has a low sensitivity for detecting adnexal masses (3). Data do not support the necessity of performing an internal pelvic examination before initiating oral contraceptives in otherwise healthy, asymptomatic individuals or as a screening examination for sexually transmitted infections (STIs) (4). Cultures for STIs can be obtained from the cervix during an internal pelvic examination. However, current evidence shows that screening for STIs also can be performed without an internal pelvic examination using nucleic acid amplification testing from urine samples or vaginal swab specimens.

Patients Younger Than 21 Years

Currently, the College recommends that the first visit to the obstetrician–gynecologist for screening and the provision of preventive services and guidance take place between the ages of 13 years and 15 years. This visit generally does not include pelvic examination. The focus of this visit should be on patient education. During this visit, the obstetrician–gynecologist can establish the clinician–patient relationship and engage in age-appropriate discussion of anatomical development, body image, self-confidence, weight management, immunizations (including the human papillomavirus vaccine), contraception, and prevention of STIs (5).

The College recommends that pelvic examinations be performed only when indicated by the medical history for patients younger than 21 years (6). An "external-only" genital examination can provide the health care provider with the opportunity to evaluate the patient for normal external genital anatomy, issues of personal hygiene, and abnormalities of the vulva, introitus, and perineum that might require further investigation. The external-only examination also provides the clinician with the opportunity to educate the patient on the range of normal female anatomy.

No evidence supports the routine internal examination of the healthy, asymptomatic patient before age 21 years, although it is recognized that pelvic pathology sometimes is identified by a pelvic examination on an asymptomatic patient. A pelvic examination always is an appropriate component of a comprehensive evaluation of any patient who reports or exhibits symptoms suggestive of female genital tract, pelvic, urologic, or rectal problems. For patients younger than 21 years with problems, such as menstrual disorders, vaginal discharge, or pelvic pain, an internal examination may be necessary.

The College guidelines for cervical cytology screening published in May 2009 now recommend beginning cervical cancer screening at age 21 years, irrespective of sexual activity of the patient (6). This is based on the current understanding of human papillomavirus infection in the adolescent patient and the pathophysiology of invasive cervical cancer.

Testing for STIs is recommended for sexually active adolescents. Nucleic acid amplification testing on urine samples or vaginal swab specimens is now an acceptable form of screening for gonorrhea and chlamydial infections (7, 8) obviating the need for cervical sampling. Other options that do not require an internal examination include self-collected vaginal swabs for diagnosing yeast infections, trichomoniasis, and bacterial vaginosis.

Patients Aged 21 Years and Older

The College guidelines recommend that a pelvic examination be performed on an annual basis in all patients aged 21 years and older (2). No evidence supports or refutes the annual pelvic examination or speculum and bimanual examination for the asymptomatic, low-risk patient. An annual pelvic examination seems logical, but also lacks data to support a specific time frame or frequency of such examinations. The decision whether or not to perform a complete pelvic examination at the time of the periodic health examination for the asymptomatic patient should be a shared decision after a discussion between the patient and her health care provider.

A pelvic examination always is an appropriate component of a comprehensive evaluation of any patient who reports or exhibits symptoms suggestive of female genital tract problems. Patients with menstrual disorders, vaginal discharge, infertility, or pelvic pain should receive a pelvic examination. Perimenopausal patients with abnormal uterine bleeding, changes in bowel or bladder function, or symptoms of vaginal discomfort should have a pelvic examination. Pelvic symptoms related to later reproductive years and menopause, such as abnormal bleeding, vaginal bulge, urinary or fecal incontinence, or vaginal dryness, warrant a pelvic examination. Bimanual examination is indicated before procedures, such as an endometrial biopsy, inserting an intrauterine device, or fitting a diaphragm or pessary. A patient's personal and family medical history and known risk factors for gynecologic malignancies can affect the decision regarding the indications for a pelvic examination. An exhaustive list of specific indications for a pelvic examination for all patients is beyond the scope of this document. Sound clinical judgment always must be the guiding factor in determining when a pelvic examination is indicated.

The decision to receive an internal examination can be left to the patient if she is asymptomatic and has undergone a total hysterectomy and bilateral salpingo–oophorectomy for benign indications and has no history of vulvar intraepithelial neoplasia, cervical intraepithelial neoplasia 2, cervical intraepithelial neoplasia 3, or cancer;

is not infected with human immunodeficiency virus (HIV); is not immunocompromised; and was not exposed to diethylstilbestrol in utero. Cytology testing is not recommended in this select population. Annual examination of the external genitalia should continue. Also, it would be reasonable to stop performing pelvic examinations when a woman's age or other health issues reach a point where the woman would not choose to intervene on conditions detected during the routine examination, particularly if she is discontinuing her other routine health care maintenance assessments. This conclusion can be documented after a process of shared and ongoing communication and decision making between the patient and physician (9).

Clinical Breast Examination

No data exist regarding the ideal age at which to begin clinical breast examinations in the asymptomatic, low-risk patient. Expert opinion suggests that the value of clinical breast examination and the ideal time to start such examinations is influenced by the patient's age and known risk factors for breast cancer. The occurrence of breast cancer is rare before age 20 years and uncommon before age 30 years (10). Based on available evidence, the College, the American Cancer Society (ACS), and the National Comprehensive Cancer Network recommend that clinical breast examination be performed annually in women aged 40 years and older. Although the value of a screening clinical breast examination for women with a low prevalence of breast cancer (eg, women aged 20–39 years) is not clear, the College, ACS, and the National Comprehensive Cancer Network continue to recommend clinical breast examination for these women every 1–3 years (11). All three organizations also recommend the teaching of breast self-awareness and inquiry into medical history and family history of risk factors for breast disease. Breast self-awareness educates patients about the normal feel and appearance of their breasts (12). For many patients, breast self-awareness also may include performing breast self-examinations. Both modalities have the potential to alert the patient to changes in her breast that should be reported immediately to her physician and may lead to earlier detection of breast cancer.

Mammography is the primary tool for breast cancer screening, and the roles of the clinical breast examinations and breast self-examinations have been questioned by some experts. The 2009 U.S. Preventive Services Task Force report on breast cancer screening states that "current evidence is insufficient to assess the additional benefits and harms of clinical breast examinations beyond screening mammography in women 40 years and older" (13). The data evaluated by the U.S. Preventive Services Task Force in its 2009 recommendation suggest that teaching breast self-examination does not reduce the mortality rate of breast cancer and it recommends against clinicians teaching women how to perform breast self-examination (13). However, 8–17% of cases of breast cancer are missed by mammography (14). The clinical breast examination and breast self-awareness, which may include breast self-examination, have the potential to detect a palpable cancer. Some studies show that clinical breast examination and mammography together have a better sensitivity than mammographic screening alone for detecting breast cancer (15–17). Thus, the clinical breast examination still is recommended as part of the periodic health examination of women, especially those with known risk factors for breast cancer.

Shared Communication and Decision Making

The decision to perform an internal pelvic examination, breast examination, or both should be made by the physician and the patient after shared communication and decision making. Concerns, such as individual risk factors, patient expectations, or medical–legal concerns may influence the decision to perform an internal pelvic examination or clinical breast examination. In these situations, the medical record should reflect the pertinent details of the patient's medical and family history and overall condition, documentation of the physical examination, and the issues discussed between the patient and physician. The decision to perform any type of pelvic or breast examination should always be made with the consent of the patient.

Conclusions and Recommendations

- An annual visit provides an excellent opportunity to counsel patients about maintaining a healthy lifestyle and minimizing health risks.
- The annual health assessment should include screening, evaluation and counseling, and immunizations based on age and risk factors.
- Speculum examinations for cervical cancer screening should begin at age 21 years, irrespective of sexual activity of the patient.
- A pelvic examination always is an appropriate component of a comprehensive evaluation of any patient who reports or exhibits symptoms suggestive of female genital tract, pelvic, urologic, or rectal problems.
- The decision to receive an internal examination can be left to the patient if she is asymptomatic and has undergone a total hysterectomy and bilateral salpingo–oophorectomy for benign indications and has no history of vulvar intraepithelial neoplasia, cervical intraepithelial neoplasia 2, cervical intraepithelial neoplasia 3, or cancer; is not infected with HIV; is not immunocompromised; and was not exposed to diethylstilbestrol in utero. Cytology testing is not recommended in this select population. Annual examination of the external genitalia should continue.
- Breast self-awareness, which for many patients also may include performing breast self-examination, is recommended. The patient should immediately report changes in her breast to her physician.

- Based on available evidence, the College, ACS, and the National Comprehensive Cancer Network recommend that a clinical breast examination be performed annually in women aged 40 years and older. In women aged 20–39 years, the College, ACS, and the National Comprehensive Cancer Network continue to recommend a clinical breast examination every 1–3 years.
- The decision to perform any type of pelvic or breast examination should always be made with the consent of the patient.

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