

Women's Health: Take-home Messages and Clinical Pearls

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- Areas of interest: Trauma-informed Care, Women's Health, Medical Education, Narrative Medicine

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Learning Objectives

1. Describe key learnings from Women's Health presentations
 2. Identify clinical pearls across these presentations
- New Developments in Cervical Cancer Screening – *Goodman*
 - Medical Complications of Pregnancy – *Seely*
 - Contraception – *Braaten*
 - Medication Abortion – *Bachorik*
 - Menstrual Irregularities – *Yialamas*
 - Menopause – *Iyer*
 - Osteoporosis – *Chou*
 - Interpersonal Violence and Trauma-informed Care – *Rittenberg, Savage-Borne*



Cervical cancer screening



Cervical Cancer Screening Guidelines

Many updates in 2026 – what are the areas of consensus and where are there still important differences?



Cervical Cancer Screening Guidelines

Age	 2024 (draft)	 2026 Update	 2025 Update
21-24	• Cytology q3yrs	• Cytology q3yrs	• No testing
25-29			• Clinician-Collected Primary HPV q5yrs • Co-test q5yrs • Self-Collect Primary HPV q3yrs • Cytology q3yrs
30-64	• Clinician-Collected Primary HPV q5yrs • Co-test q5yrs • Self-Collect Primary HPV (HC setting) q5yrs • Cytology q3yrs	• Clinician-Collected Primary HPV q5yrs • Co-test q5yrs • Self-Collect Primary HPV q3yrs • Cytology q3yrs (if no HPV testing options)	
Exit criteria Age >65 Avg risk	In past 10 years: • 2 neg Primary HPV • 2 neg co-tests • 3 neg cytology	In past 10 years: • 2 neg Primary HPV • 2 neg co-tests • 3 neg cytology	• 2 neg Primary HPV at age 60 & 65 • 2 neg co-tests at age 60 & 65 • 3 neg cytology in past 10 yrs, last at 65 (if no access to HPV testing)



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HPV Self-Collection Increases Cervical Ca Screening Rates

USPSTF systematic review: in 40 of 42 studies, self-collected primary HPV testing increased cervical cancer screening rates – especially among individuals who were underscreened or from traditionally underscreened populations.

*Most studies were of at-home self-screening.

Limitations:

- Only for average-risk patients
- At-home availability is currently limited (proprietary company only)
- Requires appropriate follow-up, which has extra complexities:
 - follow-up speculum exam needed for some positive HPV results
 - time intervals for screening differ



HPV Self-Collection Increases Cervical Ca Screening Rates

Benefits:

- Decreases discomfort: pelvic exam can be uncomfortable, esp postmenopausal, vaginismus; or difficult due to physical/mobility challenges
- Decreases retraumatization: pelvic exam may provoke distress, shame, gender dysphoria, or be culturally unacceptable
- Logistically easier: home collection avoids scheduling, transport, childcare conflicts
- Often preferred by patients

- Frees up clinician time for other care during visit
- Addresses clinician shortages, prevents delays due to long waits for appointments



Helping Patients Achieve Their Reproductive Goals



Contraception update



Dimensions of Contraceptive Choice



Effectiveness



Degree of user control



Prescription



Time to effectiveness



Hormonal / non-hormonal



Non-contraceptive benefits



Partner involvement



Ease and frequency of use

Evaluating contraceptive eligibility

CDC recommends US Medical Eligibility Criteria for Contraceptive Use (US MEC):

Category 1: No restriction

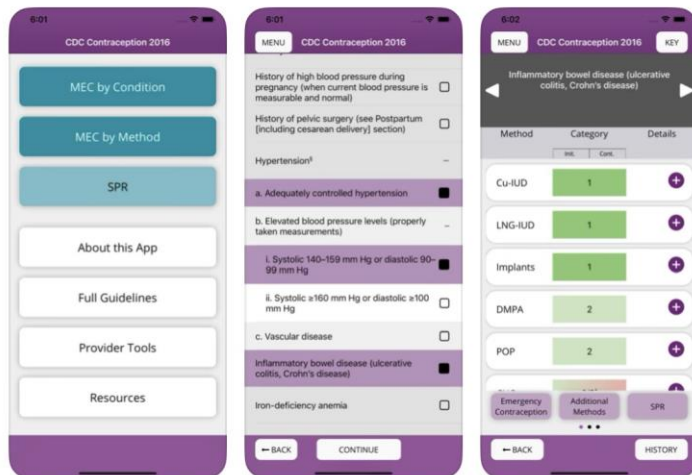
Category 2: Advantages generally outweigh risks

Category 3: Risks usually outweigh advantages

Category 4: Unacceptable health risk

US MEC (2/2025, briefly removed; now available, with disclaimer)

WHO Contraception



Medical complications of pregnancy



Hypertension in Pregnancy

Risks:

- Fetal/neonate: low birth weight and induced prematurity
- Maternal: HTN Exacerbation → MI, CVA, AKI; superimposed preeclampsia (1 in 4)

Preconception:

- Stop ACEI/ARBs – Ask re pregnancy intention before prescribing

Treatment:

- 1st line: alpha-beta blocker (labetalol) or CCB (nifedipine)
- 2nd line: methyldopa (less favored now due to side effects/efficacy)
- Can often taper by third trimester
- Goal BP <140/90, based on CHAP trial



Diabetes in Pregnancy

Risks:

- Fetal: birth defects, macrosomia, prematurity, birth trauma, neonatal hypoglycemia
 - *Birth defect risk directly related to A1c at conception
- Maternal: diabetic complications, preeclampsia, increased c/s risk

Preconception:

- Goal A1c < 6.5%
- Switch to insulin (including discontinue GLP1-RA ,ideally at least 1-2 mo prior)

Treatment:

- Diet and glucose monitoring are mainstays
- Insulin requirement increases as pregnancy progresses
- **Goal A1c <6%** (if achievable without too much hypoglycemia)

Postpartum: 60-70% risk of future T2DM. Screen women with GDM at 1y then q1-3y.



Hypothyroidism in Pregnancy

Risks:

- Fetal: pregnancy loss, stillbirth, preterm birth, impaired neurodevelopment
- Maternal: higher risk of preeclampsia, placental abruption

Preconception/at pregnancy:

- Screen women with T1DM, family hx thyroid dis, or hypothyroid sx

Treatment:

- During pregnancy, thyroid hormone requirement increases; Postpartum, returns to pre-pregnancy baseline
- At conception and throughout pregnancy: **Goal TSH <2.5**
- At delivery: reduce to pre-pregnancy dose. Check TSH at 6 weeks postpartum

*TSH value may be suppressed in 1st tri due to HCG rise.



Medication Abortion



Medication Abortion Is Common and Safe in the US

- 1 in 5 pregnancies result in abortion
- 1 in 4 women will have an abortion by age 45
- Medication abortion was 63% of all abortions in 2023
- Serious adverse event = 0.5%
- Mortality rate = 0.7 per 100,000 (13 times safer than childbirth)
- Evidence supports safety of screening with history alone (without pelvic exam or ultrasound)



Medication abortion care

Pre-abortion care:

- Options counseling

Medication abortion:

- Up to 10 wks gestational age
- Rare contraindications
- Mifepristone and misoprostol over 24-48 hours; be aware of misoprostol-only regimen

Post-abortion care:

- Confirm completion
- Assess for rare complications
- Contraception if desired



Menstrual Irregularities



Secondary Amenorrhea

Absence of menses for 3 months in a person who previously menstruated

Causes (but first, exclude pregnancy!):

- Hypothalamic
- PCOS
- Primary ovarian insufficiency
- Pituitary (e.g. hyperprolactinemia)
- Thyroid
- Outflow tract

Evaluation:

- **Key labs:** β HCG, FSH & estradiol, Prolactin, TSH
- Provera challenge – if no bleed: low estrogen state or outflow tract
- Brain MRI: if headache/neurologic signs, elevated Prolactin, unclear history
- DEXA: in pts with >6 months of amenorrhea



Hypothalamic Amenorrhea

Etiology: Energy output > input: Weight loss, excess exercise, stress, disordered eating

Diagnosis: History & physical exam, normal FSH, low estradiol, no bleed to progestin challenge; brain MRI if indications; DXA scan if ≥ 6 mo amenorrhea

Treatment :

- Weight gain, reduce exercise, increase intake
- Psychological support/CBT
- Estrogen replacement if 6 months amenorrhea
- Calcium and Vit D

What about counseling athletes? (Relative Energy Deficiency in Sport: RED-S)

- frame as energy availability, not weight: need adequate fuel for performance
- state that amenorrhea is not healthy/necessary, even for athletes
- explain reversibility, and timeline up to 12 mo for menses to resume



Polycystic Ovarian Syndrome (PCOS) = Polyendocrine Metabolic Ovarian Syndrome (PMOS)

Rotterdam Criteria (2 of the following): Oligo/anovulation, Hyperandrogenism, Polycystic ovaries on ultrasound

Exclusion of other diseases: Hyperprolactinemia, CAH, androgen-secreting tumors

Treatment: Weight loss, OCP, Spironolactone/hair removal, Metformin, Assisted Reproduction (ovulation induction, IVF)

Weight management in primary care:

- Set SMART goals and minimize weight stigma: partner with patient for goals
- Increase exercise + restrict calories: goal 5-10% weight loss; lifestyle benefits even without weight loss
- What about GLP-1RAs? Especially promising for metabolically high-risk phenotype (obesity, insulin resistance, visceral adiposity)- but sparse PCOS-specific data so far.



Primary Ovarian Insufficiency

Elevated FSH in women age < 40 (measure twice!)

Etiology

- Turner's syndrome & fragile X pre-mutations; Autoimmune ;iatrogenic: Chemo or XRT

Evaluation

- Karyotype, Fragile X pre-mutation screen, Antithyroid & anti-adrenal antibodies

Management in primary care:

- HT at replacement level dose (higher than postmenopausal HT!) or OCPs if contraception needed (intermittent ovulation may occur) - until 50-51yo
- Calcium and Vit D
- Attention to emotional impact of diagnosis, fertility impacts
- Cardiovascular risk reduction



Menopause



Vasomotor symptoms: Menopausal Hormone Therapy

Benefits:

- The most effective treatment for VMS
- Also improves other menopause symptoms, QOL, and bone health

Risks:

- Breast cancer:
 - Estrogen alone: No increase risk.
 - E + P: RR 1.26 (excess risk = 3/1,000 women taking HT x5 yrs). No increase breast ca mortality.
- VTE/stroke/PE: lower risk with transdermal compared to oral

Timing effect: When started at age <60yo or within 10 years of menopause in otherwise healthy women, HT benefits > risks.



Individualize therapy and use shared decision-making

Vasomotor symptoms: Nonhormonal treatments

FDA-approved medications:

- Paroxetine 7.5-10mg at night. SSRIs, esp paroxetine & fluoxetine, relatively contraindicated w tamoxifen
- Fezolinetant: Neurokinin-3 receptor antagonist. Boxed warning re: liver injury. Check LFT baseline, 1, 2,3,6, 9 mo
- Elinzanetant: dual NK-1/NK-3 receptor antagonist. Check LFT baseline, 3 mo

Off-label medications:

- Several SSRI/SNRIs, oxybutynin, gabapentin

Cognitive behavioral therapy, clinical hypnosis

Herbal/other therapies:

- soy, black cohosh, rhubarb, probiotics, cannabis - **not** shown efficacy



Genitourinary syndrome of menopause (GSM)

Very common (>50%), under-reported, often perceived as “normal”

Treatment:

- Mild symptoms: OTC lubricants with intercourse, daily moisturizers
- Moderate to severe symptoms: vaginal estrogen
 - NOT associated with increased endometrial cancer, VTE/PE, breast cancer, stroke
 - Multiple formulations, per patient preference
 - Other options include vaginal DHEA, oral ospemifene



Osteoporosis



Screening for osteoporosis in women

Bone Density - DEXA

- Age 65+
- Age 50-64 with Risk Factors:
 - Glucocorticoid (≥ 3 mo); Low weight (<127 lbs or BMI <20); Family hx osteoporotic fracture; Early menopause; Current smoking; Alcohol; Xray showing osteopenia
- Age 50+ after fragility fracture



Who to treat

- History of hip or vertebral fragility fractures – regardless of bone density
- DEXA T score $\leq$ 2.5 (osteoporosis) at LS spine, FN, or total hip
- DEXA T score between -1 and -2.5 (osteopenia) **and** FRAX 10 yr prob of major OP fx $\geq$ 20% or hip fx $\geq$ 3%, or proximal humerus, pelvis, wrist fracture

FRAX Calculator - Risk Assessment Tool: [Fraxplus.org/](https://fraxplus.org/)
Assess the 10-year risk of major osteoporotic fracture and hip fracture
(If >7.5mg/d prednisone, multiply by 1.15 for major OP fracture, 1.2 for hip fracture)

- Secondary work-up Prior to osteoporosis treatment



Treatment

Non-pharmacologic:

- Stop smoking; reduce ETOH
- Weight-bearing & muscle-strengthening exercises
- Vitamin D3 800-1200 IU : goal >30ng/ml
- Calcium in diet 800-1200 mg, supplement if diet not enough

Pharmacologic:

Antiresorptives

- Bisphosphonates: Oral - reduce vertebral, hip, non-vert fx; IV - reduce hip, vertebral fx
- Raloxifene - reduces vertebral fx only
- Denosumab - reduces vertebral, hip, non-vertebral fx. D/c -> rebound bone loss.

Anabolics

- Consider in very low bone density or hx vertebral fx. Use PRIOR to antiresorptive rx.
- Endocrine consult



Prevention – Hormone Therapy

- Reduces fractures in postmenopausal persons
- FDA Approved for prevention of osteoporosis in women at high risk of osteoporosis, for whom non-estrogen medications are not appropriate
- Especially consider in perimenopausal/early menopausal women with osteopenia and/or at high risk of osteoporosis, and in women with bothersome VMS
- USPSTF acknowledges that hormone therapy is associated with decreased fracture risk; however, given overall benefits and harms, concludes no net benefit

Mangione CM, et al (2022). Hormone Therapy for the Primary Prevention of Chronic Conditions in Postmenopausal Persons: US Preventive Services Task Force Recommendation Statement. *JAMA : The Journal of the American Medical Association*, 328(17), 1740–1746. <https://doi.org/10.1001/jama.2022.18625>

Management of osteoporosis in postmenopausal women: the 2021 position statement of The North American Menopause Society. *Menopause*. 2021 Sep 1;28(9):973-997. doi: 10.1097/GME.0000000000001831. PMID: 34448749.



Trauma-Informed Approach to Intimate Partner Violence



Intimate Partner Violence

IPV very common:

- Contact Sexual Violence, Physical Violence, and/or Stalking by Intimate Partner: almost half of women in the US
- Long-term health effects: Chronic pain, Vaginal infections, STIs, Depression, Anxiety, PTSD, GI symptoms, Unwanted pregnancy, Poor self-reported health, Increased healthcare utilization

USPSTF recommends screening reproductive-age women, esp pregnant

Inquiry about trauma and IPV can be an intervention

- De-stigmatize, Create safe place for disclosure, Offer resources



Addressing Confidentiality of IPV Screening

Informed consent: Review limits of confidentiality with your patient. They have the right to decide whether or not to disclose relationship information.

Mandatory Reporting: Most states do not require reporting of adult IPV – but there are exceptions, and IPV reporting laws differ by state:

Complete list as of 2019: <https://futureswithoutviolence.org/wp-content/uploads/2025/02/Compendium-4th-Edition-2019-Final.pdf>

Typical areas of concern:

- Abuse of person with disabilities, older adult, or child
- Injuries from weapon (knife/gun)

Recognize that filing, though necessary, may escalate the situation.

Ask for support! Know your local resources & experts



Trauma-informed care

Trauma-Informed Care is an approach to improve patient engagement, mitigate trauma impacts, and work towards health equity

Universal approach assumes all potentially have trauma: Disclosure of trauma is **not the goal**

TIC principles:

- Safety: physical and psychological
- Trustworthiness and transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice and choice
- Cultural, historical, and gender acknowledgment



MOC REFLECTIVE STATEMENT

1. Women's health is a rapidly evolving field, as emerging data shape new guidelines and best practices
2. Ongoing learning and a person-centered, trauma-informed approach aim to improve care, reduce disparities, and contribute to closing the women's health gap

