TABLE 70-2 SCREENING RECOMMENDATIONS FOR CERVICAL CANCER

AGE	USPSTF	ACS/ASCCP/ASCP	COMMENTS AND RATIONALE
<21	No screening before the age of 21 despite time of sexual activity	No screening before the age of 21 despite time of sexual activity	HPV positivity and cytologic abnormalities are likely to regress in young women.
21-29	Screening with liquid-based or conventional cytology alone every 3 yr; HPV testing should not be performed.	Screening with liquid-based or conventional cytology alone every 3 yr; HPV testing should not be performed.	HPV co-testing should not be used for women <30 yr of age because incidence of HPV is high and cytologic abnormalities are often transient, leading to unnecessary and sometimes harmful interventions
30-65	Cytology alone every 3 yr or cytology with co-testing every 5 yr	Co-testing with cytology and HPV every 5 yr (preferred method) *or* cytology alone every 3 yr if HPV testing in not available	
>65	No further testing if adequately screened in the past and not otherwise at increased risk for cervical cancer	No further testing if adequately screened in the past	Adequate screening defined as two negative results in the past 10 yr with one in the past 5 yr and no history of CIN2 or greater grade neoplasia. Because cancer risk decreases with age and prior normal Pap tests, overtesting may to lead to false-positive test results.
After hysterectomy	No further screening if no CIN2 or higher grade neoplasia	No further screening if no CIN2 or higher grade neoplasia	Clinicians should confirm that total hysterectomy was performed.
HPV vaccinated	Continue recommended screening	Continue recommended screening	

ACS, American Cancer Society; ASCCP, American Society of Colposcopy and Cervical Pathology; ASCP, American Society for Clinical Pathology; CIN 2, cervical intraepithelial neoplasia with moderately abnormal cells; HPV, human papillomavirus; Pap, Papanicolaou smear; USPSTF, U.S. Preventive Services Task Force.

contraception. Two types of IUDs are available in the US, and both are almost as effective as sterilization. The copper IUD can be left in 10 years, and the progesterone IUD can be left in for 5 years. The copper IUD can be associated with heavier menstrual bleeding and cramps. The progesterone IUD may initially have breakthrough bleeding, but almost one half of users become amenorrheic. Implanon is a progesterone rod that is implanted under the skin and is highly effective for 3 years. It can be placed in outpatient offices and is helpful in limiting dysmenorrhea, but it is associated with irregular menses.

Postcoital emergency contraception can be achieved with one or several hormonal options or with placement of a copper IUD. Hormonal options are available over the counter in the United States, and recommended use is up to 72 hours after intercourse. After contraception is discontinued, the time of return to fertility depends on the type of contraceptive used. The average time for return to fertility with combination hormonal contraceptives is 3 months. With DMPA, fertility can be delayed by 12 to 22 months.

Pregnancy

Preconception Counseling and Pregnancy Planning

Preconception counseling begins by obtaining a through medical history to assess potential risks to the mother and fetus. Women with a personal or family history of genetic disorders may benefit from formal genetic counseling. For the woman with no significant medical problems and no serious family medical history, education about maintaining a healthy lifestyle, nutritional supplementation, and avoidance of toxicities to the fetus are important.

In 2009, the Institute of Medicine published guidelines for weight gain during pregnancy and recommended that women planning pregnancy achieve their normal BMI before conception. Advising and assisting the overweight or obese patient in weight loss efforts before pregnancy can prevent gestational diabetes, adverse fetal outcomes, and pathologic musculoskeletal conditions. Avoidance of tobacco, alcohol, and illicit drugs is critical because they are harmful to both mother and fetus. All women planning pregnancy or capable of becoming pregnant should be advised to take a daily multivitamin with folic acid (400 to 800 μg) to reduce the risks of neural tube defects and other congenital anomalies, including cardiovascular defects, urinary defects, and cleft lip.

Routine laboratory evaluation includes rubella titer, varicella titer (in women with a negative history of varicella), hepatitis B surface antigen, and a complete blood count (CBC), assessing for hemoglobinopathy. Women should receive HIV testing and counseling.

An important goal is to ensure that women are immune to measles, mumps, rubella, tetanus, diphtheria, poliomyelitis, and varicella. Women should receive influenza vaccine in pregnancy due to the increased risk of complications from influenza infection. Ideally, women should receive all indicated vaccinations at least 1 month before conception. Live vaccines (e.g., rubella) should not be given during pregnancy.

The patient's medications, including prescribed, over-the-counter, and herbal medications, should be reviewed to identify potential teratogens. Medications not considered absolutely necessary for the well-being of the mother or fetus should be stopped. This is not always possible or indicated for women being treated for chronic medical conditions.

Medical conditions known to increase the risk of adverse pregnancy outcomes for women and their offspring include diabetes, thyroid disease, seizure disorders, hypertension, rheumatoid arthritis, chronic renal disease, thrombophilias, asthma, and cardiovascular disease. Preconception care of these conditions can improve pregnancy outcomes. Patients usually are referred to high-risk pregnancy care for evaluation. Approximately 1% of pregnancies in the United States are complicated by pregestational diabetes. Gestational diabetes (GDM) occurs in approximately 7% of pregnancies. GDM has a high recurrence rate (30% to 80%) in subsequent pregnancies and a significantly increased