TABLE 70-4 FOOD AND DRUG ADMINISTRATION CATEGORIES OF DRUG SAFETY DURING PREGNANCY

CATEGORY	INTERPRETATION
A	Adequate, well-controlled studies in pregnant women have not shown an increased risk to the fetus in any trimester of pregnancy.
B	Animal studies have revealed no evidence of harm to the fetus; however, there are no adequate and well-controlled studies in pregnant women. *Or* Animal studies have shown an adverse effect, but adequate and well-controlled studies in pregnant women have failed to demonstrate a risk to the fetus in any trimester.
C	Animal studies have shown an adverse effect, and there are no adequate and well-controlled studies in pregnant women. *Or* No animal studies have been conducted, and there are no adequate and well-controlled studies in pregnant women.
D	Adequate, well-controlled, or observational studies in pregnant women have demonstrated a risk to the fetus. However, the benefits of therapy may outweigh the potential risk.
X	Adequate, well-controlled or observational studies in animals or pregnant women have demonstrated positive evidence of fetal abnormalities or risks, and the use of the product is contraindicated in women who are or may become pregnant.

conditions. Few medications are absolutely contraindicated in pregnancy. Decisions about continuing or stopping medications require a discussion about the risks and benefits and an informed decision on the part of the woman.

Pregnancy Complications and Risk of Future Diseases

Women with a history of gestational diabetes are at increased risk for diabetes later in life. Women whose pregnancies were complicated by a gestational hypertensive disorder, such as preeclampsia or gestational hypertension, are at increased risk for subsequent essential hypertension. Women who have a history of a child with a neural tube defect should take 4 g of folic acid daily. Women with a prior problem pregnancy may benefit from close follow-up with an obstetric provider such as a high-risk pregnancy specialist to reduce subsequent problems.

Two important conditions to recognize are postpartum depression and postpartum thyroiditis. Postpartum depression may complicate 10% to 15% of pregnancies. The symptoms are the same as those of clinical depression in a nonpregnant woman. Risk factors for postpartum depression include a history of depression before pregnancy and depression during the current pregnancy. Postpartum thyroiditis may be seen in 7% to 8% of women. Only about one third of women have the classic hyperthyroid phase followed by hypothyroidism and recovery. Another 30% exhibit only hyperthyroidism, and the remaining 40% to 50% have only hypothyroidism. Unexpected symptoms after delivery should prompt an evaluation of thyroid function.

Lesbian Health

Being lesbian is not a homogeneous experience. The racial, ethnic, and socioeconomic diversity of the United States is mirrored in the lesbian community. The Institute of Medicine released a report acknowledging that lesbian, gay, bisexual, and transgender (LGBT) individuals experience unique health care disparities and encouraged health care providers to increase cultural competence to care for these populations. Lesbians are significantly more likely than heterosexual women to experience discrimination during health care visits. Many providers do not take a sexual history or inquire about sexual orientation. Health care providers may inadvertently assume heterosexuality and communicate heterosexist attitudes, making it more difficult for patients to disclose their sexual orientation. Physicians can create a safe and welcome environment for their lesbian patients by consistently adopting gender-neutral language. For example, "Do you have a significant other?" rather than "Are you married?" It is also important that confidentiality is ensured and that staff are aware of and comfortable with lesbian patients and their families.

Between 50% and 80% of lesbians report heterosexual sexual activity (which confers the highest risk for HPV acquisition) at some point in their lives, and screening for cervical cancer should follow the same guidelines as for heterosexual women. Although many STIs occur less frequently in lesbians, screening should be considered when appropriate. Counseling about lifestyle issues and screening when appropriate are the same for lesbians as for heterosexual women.

TABLE 70-5 CAUSES OF SECONDARY AMENORRHEA

CAUSE	EXAMPLES
Physiologic changes	Pregnancy, lactation, menopause
Ovarian changes	Radiation- or chemotherapy-induced ovarian failure, chromosomal abnormalities, autoimmune or idiopathic
Anovulation	Hyperandrogenism (polycystic ovary syndrome, congenital adrenal hyperplasia), hyperprolactinemia (prolactinoma, phenothiazines, narcotics, and other medications), hyperthyroidism, hypothyroidism, hypopituitarism, pituitary adenoma, Cushing's syndrome, hypothalamic hypogonadism (eating disorder, athletic triad, stress)
Medications	Hormonal, cytotoxic, others
Uterine outflow abnormalities	Surgery, Asherman's syndrome

Gynecologic Issues

Menstrual disorders are common and usually categorized as *amenorrhea* and *abnormal uterine bleeding*. Abnormalities may indicate problems related to the reproductive system or may be an early sign of an important underlying systemic illness.

Amenorrhea

Amenorrhea occurs in 5% of women each year. It is the absence of menses for at least 3 to 6 months outside of the setting of pregnancy or lactation. Women with a previously established menstrual pattern have *secondary amenorrhea* (Table 70-5). *Oligomenorrhea* occurs when menses are irregular or infrequent, with a cycle length usually greater than 35 to 40 days, and it is often associated with *chronic anovulation* or oligo-ovulation. The most common cause of secondary amenorrhea is pregnancy. Lactation causes amenorrhea for up to 6 months in a woman who is exclusively breast-feeding her infant. Prolonged amenorrhea can follow cessation of some hormonal contraceptives, especially