



common malignancy causing discharge is ductal carcinoma in situ. However, a benign intraductal papilloma is the most common cause of bloody nipple discharge.

Most bilateral discharge that occurs only with manipulation is a normal physiologic response. Galactorrhea, bilateral milk production occurring in a nonlactating woman, can be seen in many conditions, including prolactinomas, thyroid dysfunction, and chronic renal failure. It can be a response to many drugs, including antipsychotics, oral contraceptives, and marijuana.

Initial evaluation for breast discharge includes a pregnancy test, prolactin level determination, and thyroid tests. If there is concern about malignancy, a breast specialist performs cytology, immunology, and occult blood testing on the discharge and obtains mammography and ultrasound studies.

There are four categories of breast masses: abscesses, benign masses, benign tumors, and cancer. Benign masses include cysts, galactoceles, papillomas, and fibroadenomas. Cancerous masses are typically painless, dominant masses that persist. Although breast cancers have characteristically been described as hard and immobile with irregular borders, no examination finding reliably distinguishes between a benign and cancerous mass.

Persistent masses require evaluation, which may include ultrasound, mammography, and biopsy, depending on the findings from the history, physical examination, and patient's age. Women younger than 30 years of age are at lower risk for malignancy. Ultrasound is the first imaging modality indicated for young women. If the mass is a cyst, it can be aspirated if symptomatic. If the mass is solid and is not characteristic of a fibroadenoma (which can be observed or biopsied), a biopsy is indicated to rule out malignancy. In women older than 30 years of age, mammography is the first diagnostic test that should be ordered, even if the woman had a recent negative screening mammogram. Ultrasound is often done simultaneously to further evaluate the mass or an area of abnormality detected on the mammogram. Negative imaging results should not preclude further work-up of a clinically suspicious mass. Mammography misses 10% to 20% of clinically palpable breast cancers.

Pelvic Pain

Pelvic pain is characterized as acute or chronic, and both types are commonly encountered in primary care practice. Acute pelvic pain usually manifests over hours to days and may be gynecologic, gastrointestinal, or urologic in origin. Life-threatening conditions, including ruptured ectopic pregnancy and appendicitis, need to be ruled out. Gynecologic causes include complications of pregnancy, acute pelvic infection, and ovarian pathology, including cyst and torsion.

Chronic pelvic pain (CPP) is lower abdominal pain of at least 6 months' duration, and it is severe enough to cause functional impairment or require treatment. Approximately 10% of ambulatory gynecologic referrals are for CPP. The history obtained for evaluation of CPP should include characteristics of the pain; a thorough review of systems; prior medical, surgical, gynecologic, and obstetric history; and a thorough psychiatric and social history, including episodes of domestic violence as a child or an adult and periods of substance abuse.

The most common conditions associated with CPP include endometriosis, chronic pelvic inflammatory disease, interstitial cystitis, irritable bowel syndrome, pelvic floor myalgia,

myofascial pain, and neuralgia. Interstitial cystitis or painful bladder syndrome is a clinical diagnosis consisting of pain, pressure, or discomfort related to the bladder and associated with lower urinary tract symptoms lasting more than 6 weeks and occurring in the absence of infection or other identifiable causes. Mental health issues, including substance abuse, somatization, depression, and physical or sexual abuse, can also cause CPP and are important to identify so that women need not undergo unnecessary testing and interventions.

Physical examination should assess for focal areas of pain, scars, hernias, or masses in the abdomen, and a pelvic examination should be performed. After the most likely diagnosis has been identified, an empirical, targeted treatment may be instituted and followed for efficacy. Further work-up should be considered if the patient does not respond or symptoms change. If empirical therapy and a thorough investigation do not yield a diagnosis, laparoscopy may be considered to identify pelvic pathology.

Depending on the underlying cause, management strategies may include heat therapy (for musculoskeletal pain), counseling and psychiatric referral, gastrointestinal referral, medications (e.g., gabapentin for neuropathic pain, NSAIDs, hormonal contraceptives), hysterectomy, and nerve transection procedures. Multidisciplinary approaches, including medications and interventions that address dietary and psychosocial factors, may be superior to medical treatment alone.

Intimate Partner Violence

Intimate partner violence (IPV) is a serious, preventable public health problem. In 2013, the USPSTF revised their guidelines to recommend that clinicians screen women of childbearing age (14 to 46 years old) for IPV and provide or refer women to intervention services when appropriate. Several screening instruments detect IPV effectively, and most experts think the benefits of detection outweigh the potential harm. Providers can choose among many tools for screening, including Hurt-Insult-Threaten-Scream (HITS), Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT), and Abuse Assessment Screen (AAS).

A short but effective survey may be more practical. The STaT (i.e., slapped, threatened, and thrown things) screening tool is relatively easy to implement by asking three questions: Have you ever been in a relationship in which your partner has pushed or slapped you? Have you ever been in a relationship in which your partner threatened you with violence? Have you ever been in a relationship in which your partner has thrown, broken, or punched things?

A self-administered questionnaire may be even more effective than face-to-face questioning. When screening for and discussing IPV, the provider must be nonjudgmental and compassionate and must ensure confidentiality.

Even when historical or physical examination clues are evident, IPV often remains undiagnosed by providers. Patients often conceal abusive relationships. They may blame themselves for the abuse, or they may not be emotionally ready to acknowledge the abuse. Although there are risk factors for IPV, victims are found among people of all ages, races, ethnicities, and gender and sexual identities.

Identified risk factors for IPV include younger age, female sex, lower SES, and a family history or personal history of violence.