4.0

FAMILY PLANNING LABORATORY
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INTRODUCTION
All laboratory procedures, quality assurance monitoring and recording must be performed according to current CLIA regulations. Refer to your clinic Laboratory Manual for specific guidelines.

Clinic staff should have a discussion on the importance of recommended screening tests with the client. Following counseling about the importance of the recommended screening tests, if client chooses to decline or defer a service, this should be documented in their medical record. Counseling must include information about the possible health risks associated with declining or delaying preventive screening tests or procedures.

SERVICE POPULATION
Uninsured or underinsured reproductive-age women and men who present for Title X reproductive health services in order to plan the size of their families and birth spacing of their children.

METHODOLOGY

4.1 LABORATORY TESTS
The following laboratory tests may be ordered by the clinician when clinically indicated:

A. Cervical cytology test
B. Chlamydia/Gonorrhea test

1. For PHO

PHO Providers should screen:
- All sexually active women aged <25 years for chlamydia annually.
- Females requesting IUD insertion, regardless of age.

For diagnostic testing of high-risk PHO clients, please refer to the STD Program Protocol for testing guidelines

2. Note that the following guidelines apply to clinic sites operated by FP Provider Agreement sites (outside PHO):

Non-PHO Providers should screen:
- All sexually active women aged <25 years for chlamydia annually.
- Females requesting IUD insertion, regardless of age.

Chlamydia testing may also be provided for female and male FP clients who are <30 years old and are:
- Symptomatic, or
- those diagnosed with an STD in the last year, or
- a known contact to an STD infected partner.

Any testing outside of these parameters is not covered by the FP Provider Agreement, and the client must pay for this testing. Also ensure that all clients who are tested under the FP Provider Agreement have the appropriate health history, counseling and medical record documentation, in order to qualify them as FP clients (refer to Section 1).

C. Wet Prep test
For asymptomatic clients with normal pelvic exam, the wet prep, pH, and amine test is optional. If bacterial vaginosis (B.V.) or trichomonas is suspected or diagnosed, you may still insert IUD and start treatment on the same visit (US MEC 2).
D. Urine pregnancy test is required for provision of specific methods of contraception.

E. All other tests are done either on site or by referral:
   - Syphilis – For both PHO and non-PHO, refer to STD Program Protocol.
   - HIV- For PHO, refer to Section 1 of the FPP Protocol, Subsection 1.2.H.e STD Services.
     For non-PHO Title X clients, the HIV testing is not covered in the FPP agreement.
   - Rubella immunity status at the client’s own expense for both PHO and non-PHO.

4.2 LABORATORY RESULTS

- The clinic must have a tracking system in place for follow-up of abnormal/positive lab tests.
- There must be a designated person(s) that maintain the system.
- The system must include timely notifying a clinician of test results.

Lab results requiring a clinician’s (MD, CNM, CNP, PA) attention includes:
- Cervical cytology test unsatisfactory, ASC-US, ASC-H, AGC, LSIL or HSIL, *invasive cancer
- Chlamydia/Gonorrhea positive
- Syphilis serology reactive or positive (*pregnant client and/or HIV positive)
- TPPA positive
- HIV positive
- Hepatitis B Hepatitis B carrier status in a pregnant woman

*Immediate attention required*

- The clinician will determine appropriate follow-up based on the test result report, clinical findings, and the woman’s ability to follow-up.
4.3 LABORATORY METHODOLOGY/PROCEDURE

A. Standing Order for Public Health Nurses to Collect Specimens for Chlamydia/Gonorrhea Testing

**Purpose:** Since their epidemiological profiles are similar, CT/GC testing recommendations are the same. **Testing should not substitute client counseling/education regarding correct and consistent condom use in STD prevention.**

*Chlamydia trachomatis* is the most common bacterial STD with the highest prevalence among young women under 25 years of age. Men, women and infants are affected but women bear an inordinate burden because of their increased risk for adverse reproductive consequences. It causes cervicitis, PID and infertility in women but is often asymptomatic. It causes urethritis and epididymitis in men.

In asymptomatic women 30 years of age and over, the rate of positive CT tests is generally < 5% which makes false positive tests more likely to occur. For this reason, the FPP does not recommend screening of this population for CT and GC. Routine annual testing of low risk women over age 24 is also not recommended.

**Subjective and objective nursing assessment:**

The PHN will interview clients to obtain:
1. History: Assess the client’s RLP, complete medical history and sexual history as described in Section 1, Step 2 of sub-section 1.2.H.a. to include LMP, drug allergies in the medical record (BEHR).
2. Symptoms: to include fever, abnormal vaginal discharge, burning on urination, lower abdominal pain, abnormal vaginal bleeding, bleeding after sex, painful sexual intercourse

**Screening**
1. **Women under 25:** Test all *sexually active* women under 25 years of age **annually.**
2. **Women seeking an IUD insertion** should be screened regardless of age.

**Procedure:** Follow the package insert and PHD Standard Operating Procedures (SOP) Manual.

**Nursing assessment of normal and abnormal findings requiring notification of a clinician**

1. Positive screen for symptoms listed above might indicate that the client has pelvic inflammatory disease (PID) and requires PHN to consult a clinician as soon as possible or a referral to PMD.
2. Positive Chlamydia and/or Gonorrhea lab results require a clinician’s (MD, CNM, CNP, PA) attention. Clinician will need all the information listed under nursing assessment to make a decision whether the client needs to have a pelvic examination to rule out PID.

**Plan of care for client with either positive CT or GC lab result**

1. In an asymptomatic client without an IUD, the PHN will follow a PHD standing order or a clinician’s order to provide counseling and administer appropriate antibiotic(s) to which the client is not allergic.
2. In a client with an IUD or in a female client with any symptoms listed above,
   - If a clinician is available on-site, consult the clinician to assess the client and rule out PID.
   - If a clinician is not available on-site, contact a clinician by phone to discuss the appropriate follow-up or to obtain permission to refer the client to ER or PMD as appropriate. If unsuccessful, contact a RHO.
3. Complete a NM Morbidity Report for Sexually Transmitted Diseases for clients with positive CT/GC.
4. Inform clients with positive tests to have all partners in the last 2 months come to the clinic for testing and treatment. If there were no partners in the past two months, then the most recent sexual partner should be tested and treated. If clients are unable to contact partner(s), refer to DPS.
5. Since re-infection with CT/GC is common in the months following an initial infection, women and men with a positive CT/GC test will be given an appointment to return for a re-test (regardless of whether the client believes that sex partners were treated) approximately 3 months following treatment.
   - If the client returns sooner than the appointment date and after 4 weeks, PHN can send a urine specimen for re-testing. Re-testing should not be performed prior to 4 weeks due to the likelihood of a false positive test due to the presence of dead organisms.
   - If the client missed the 3-month appointment but returns within 12 months following treatment, PHN can still send a urine specimen for re-testing.
TREATMENT (FOR CLINICIANS)

For management of symptomatic women or laboratory-confirmed positive test results and their partners, please refer to the current CDC STD Treatment Guidelines http://www.cdc.gov/std/tg2015/default.htm.

Clients diagnosed with chlamydia that are treated with any of the recommended or alternative regimens do not need a test-of-cure (i.e., repeat testing 3-4 weeks after completing therapy).

Treatment of partners is vital to prevent re-infection of treated patients and to reduce onward transmission of infection. Counsel clients on the important role of partner services and offer clients available partner services.

NM MORBIDITY REPORT

All Title X clinics are required to complete a NM Morbidity Report for Sexually Transmitted Diseases for clients with newly diagnosed HIV, syphilis, chlamydia or gonorrhea infections or clients with any STD who are pregnant. Since these are notifiable conditions in New Mexico, this will ensure that the NM law is followed and provides notification to a Public Health Office Disease Prevention Specialist (DPS).

B. CERVICAL CYTOLOGY

1. PURPOSE:

   The test provides a means of screening for pre-invasive and invasive cervical cancer. Educate all women about the risk factors for cervical cancer (HPV infection, multiple partners, tobacco use etc.) and importance of screening. The test report includes information about the identification of organisms causing cervicitis or vaginitis. Cervical cytology tests are screening tools, not diagnostic tools. Refer any woman with a clinically suspicious cervical lesion for colposcopy with biopsy as indicated or women who must have HPV testing (either alone or as a co-test) per ASCCP Guidelines.

   The need for cervical cancer screening should not be the basis for the onset of gynecologic care. Sexually active adolescents (i.e., females younger than 21 years) should be counseled and tested for STDs and should be counseled regarding safe sex and contraception. These measures may be carried out without a cervical cytology test and, in the asymptomatic patient without the introduction of a speculum.


<table>
<thead>
<tr>
<th>Age</th>
<th>Screening interval</th>
<th>Action/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;21 years</td>
<td>No Screening</td>
<td>HPV testing should not be used for screening or management of ASC-US in this age group.</td>
</tr>
<tr>
<td>21-29 years</td>
<td>Cytology alone every 3 years</td>
<td>HPV testing should not be used for screening or management of ASC-US in this age group.</td>
</tr>
<tr>
<td>30-65 years</td>
<td>HPV and Cytology *Cotesting every 5 years (Preferred)</td>
<td>Refer women who must have HPV testing (either alone or as a co-test) per ASCCP Guidelines.</td>
</tr>
<tr>
<td>Post hysterectomy</td>
<td>No Screening</td>
<td>Applies to women without a cervix and without a history of CIN2 or a more severe diagnosis in the past 20 years or cervical cancer ever.</td>
</tr>
<tr>
<td>HPV Vaccinated</td>
<td>Follow age-specific recommendations (same as unvaccinated women)</td>
<td></td>
</tr>
</tbody>
</table>
Human Papilloma Virus (HPV) Testing

Rationale for Screening Recommendations
Pathological features from Pap smears can identify cervical disease but cannot assess the underlying risk for progression of the identified cervical abnormality. HPV testing is suitable for identification of the HPV type present but cannot identify the cervical disease. Therefore, having a combined approach identifying cellular and/or molecular abnormalities predictive of cervical cancer development (e.g., through cytology and histology) is needed to distinguish women at high-risk of cervical cancer development.

Since a positive test HPV test has a predictive value of ~20% for precancer and even less for cancer, HPV testing should be used only to detect high risk HPV types per Inside Knowledge About Gynecologic Cancer (2015, September 14 - Retrieved from https://www.cdc.gov/cancer/knowledge/provider-education/cervical/rationale.htm).

Definitions
Pap test – The Papanicolaou test (or “Pap test”) is a method of cervical cancer screening used to detect potentially precancerous and cancerous processes in the cervix. Liquid-based cytology (LBC) begins with the clinician-collected gynecologic sample added to a vial of transport medium preservative. Samples are then processed and deposited in a cell spot onto a microscope slide and examined for abnormalities. By itself, the Pap test does not directly evaluate for HPV infection.

HPV/Pap cotest - A procedure where a Pap test and a human papillomavirus (HPV) test are done at the same time to check for cervical cancer. This means that the HPV test is done regardless of the Pap result. The same cell sample may be used for both the HPV test and the Pap test. Cotesting is more likely to find abnormal cells or cervical cancer than a Pap test alone.

HPV reflex testing - The HPV test is done only if certain abnormal/inconclusive Pap test results occur. The purpose of reflex HPV testing is to help refine follow-up for women in specific age groups with a low-grade Pap test result. The testing may be set up with the laboratory to occur automatically under some conditions (not currently available) or may require an additional order by a clinician following lab resulting.

HPV testing – HPV testing, specifically without the Pap test, can be ordered on a specimen. This could occur if an HPV test on an abnormal Pap was not ordered in time, or if the original specimen is not suitable for additional testing (e.g., due to lab processing, such as acid washing). This requires that a new specimen be collected from the client.

Continued Screening Is Still Needed After HPV Vaccination
Women who have received the HPV vaccine should be screened according to the same guidelines as women who have not been vaccinated (Level C evidence). Retrieved from https://www.cdc.gov/cancer/cervical/pdf/guidelines.pdf

Program Guidelines
The US Preventive Services Task Force recommends either Pap alone (every three years) for women 21-65 years of age, with the option of using co-testing for screening women 30-65 years of age (every five years). However, routine co-testing adds significant programmatic costs. To optimize resources, PHD only uses co-testing (either through the Family Planning or the Breast and Cervical Cancer programs) for follow-up testing where advised by the American Society for Colposcopy and Cervical Pathology guidelines (August, 2014 - www.asccp.org/guidelines). The table below provides guidance for managing Family Planning clients – although FPP clients may also participate in the BCC program when eligible.

If uncertain about the recommendations, contact the Regional Health Officer or Program. For complete guidelines regarding prevention and early detection of cervical cancer, please see link below:

http://www.asccp.org/guidelines
http://www.asccp.org/store-detail2/asccp-mobile-app
**I. Pap and HPV Testing**

Please see the PHD Lab Standing Operating Procedures (SOPs - available at [http://intranet/PHD/clinical_protocols.html](http://intranet/PHD/clinical_protocols.html)) or other lab SOPs for detail on indications, contraindications, procedures, shipping, and results for Pap and HPV testing.

**II. Limitations for HPV Testing**

Liquid-based cytology (LBC) samples are held for up to 21 days post collection by the CDD. Clinicians needing to add HPV testing must request testing prior to the 21 days.

Four options with CDD:

- **a. Thin Prep [Pap only] – used for routine testing**
- **b. Thin Prep with HPV [co-testing] – use for some situations – see above**
- **c. Thin Prep with reflex HPV – must be ordered by the clinician (automatic reflex testing by the lab is not available).**
**d. Thin Prep HPV [HPV only] – used if initial Pap positive and HPV testing indicated – may be ordered on original specimen, or on a new specimen if not ordered in time or specimen processing precluded testing original specimen.**

### III. How to order HPV testing on a previously collected Pap

To add an order for HPV testing:

1. **Order the test in BEHR.**
   
   Go to the BEHR chart for the original visit and add the test – save and sign. The charge for the Thin Prep HPV will cross over to the encounter form for the original visit. Go to the encounter form and submit. The BEHR team will then see that a late charge has been added for the Thin Prep HPV.

2. **Implement the order**
   
   In AFTIS, go to the order and enter the Accession Number for the original liquid-based Pap into the HPV order;
   
   a. The nurse or clinician should complete Amendment Form and fax to CDD.
   
   b. **Ordering Issues:** If the previous accession number is not recognized by AFTIS, the nurse or clinician will need to complete the CDD Laboratory Test Amendment Form and fax it to CDD rather than calling CDD. It occasionally happens, and always happens when the clinician orders the HPV before the pap results are received back into BEHR.
   
   c. The accession number includes all the numbers except the year (for example 0149250080532019, do not enter the 2019) and the accession number should go through. If a clinician orders the HPV, she or he needs to make sure the nurse is aware (the lab will already have the pap liquid and it may cause some confusion if the nurse doesn’t see a sample to stick a label on). Then put the label in the CLIA log, the bar code label should be added to the Laboratory Test Amendment Form prior to faxing it. The completed form can be faxed to 888-858-8664.

   OR

3. **Call the Center for Disease Detection (CDD) at 1-888-858-8663, Extension 1 (Client Care) to add HPV testing.**
LABORATORY TEST AMENDMENT FORM

(DO NOT USE THIS FORM FOR BILLING PURPOSES)
PLEASE COMPLETE EACH SECTION AS INDICATED. FOR ANY QUESTIONS CALL 888-858-8663.

1. SELECT APPLICABLE CATEGORY
   □ Patient Details   □ Test Details   □ Add/Change Test
   Examples: Date of Birth, I.D. #  Examples: # of vials, source  Examples: HIV, TP-PA, RPR

2. EXPLAIN ORIGINAL ENTRY AND PROVIDE CORRECTION

3. PROVIDE REQUIRED INFORMATION

   CLINIC INFORMATION
   Account #:  Clinic Name:

   PATIENT’S INFORMATION
   Last Name:  First Name:  M.I.:
   Accession Number:  Date of Birth:  Date of Service:

   REQUESTOR’S INFORMATION
   Name:  Title:  Date:
   Signature:  Phone #:  Alt. Phone #:  

4. USE THIS SECTION ONLY WHEN ADDING OR CORRECTING TESTS

   Use the AFTIS computer program to complete patient entry.
   Select the correct lab test, print the barcode label, and place it in the space provided. Transmit patient data electronically.

   NOTE: CDD retains specimens requiring correction provided the specimen meets test stability criteria.

5. WHEN COMPLETED FAX THIS FORM TO 888-858-8664

   FOR CDD USE ONLY
   Fax Receive Date:  Signature & Title:

   REQUEST FOR ADDITIONAL TESTING
   Date Specimen Received:  Rack:  Position:
   Original Test Performed:  Original Test Accession #:  
   New Test Requested:  New Test Accession #:  

   FOR LABORATORY USE ONLY (TEST COMPLETED)
   Test Result Code:  Tech Initials:  Result Date:
   Reviewed by:  Review Date:
   □ REJECTED  Reason for Reject:  Site Notification date for rejection:
IV. Best Practice for Patient Education

Women who have received abnormal cervical results indicate that they experience adverse psychological reactions to their HPV diagnosis. Reactions to consider while counseling patients on HPV diagnosis include:

- Anxiety, anger, regret
- Fears of cancer
- Pregnancy related outcomes
- Concerns about negative reactions from friends, family or sexual partners
- Concerns about partner infidelity
- Hostility towards person believed to be the source of infection
- Changes in body image
- Decrease in physical intimacy activities
- Difficulty with understanding the differences between low and high-risk strains of HPV
- Confusion with how pap test results could be normal if HPV is present

Educational disparities and psychosocial concerns can decrease adherence for follow up. Research has shown that women desire information on transmission, prevention, detection, treatment and progression with treatment, and risk of cervical cancer (Anhang, Goodman, & Goldie, 2008, https://onlinelibrary.wiley.com/journal/15424863).

It is important to emphasize with the patient that HPV is very common, HPV is sexually transmitted, most women that have HPV will not develop cervical cancer, HPV can clear without treatment, the purpose of a Pap testing, the purpose of HPV testing, and a diagnosis with high risk HPV may not indicate cervical cancer on further evaluation.

V. Additional Resource Links

For more information on lab SOPs, please see link below:
- http://intranet/PHD/clinical_protocols.htm

For more information regarding sources of information for women about HPV and cervical cancer, please see links below:
- American Sexual Health Association (ASHA)
  http://www.ashasexualhealth.org/standards/hpvmymbtah FACTS/ HTML
- National Cervical Cancer public education campaign
  http://www.cervicalcancer.org/hpvfacts/index.html
- American Cancer Society

For more information on best practices, please see link below:

For more information on best practices, please see link below:
- Website: ASCCP@ http://www.asccp.org/guidelines
- Mobile App: Available for Android, iPhone, also available in Spanish. Go to the mobile app store, "ASCCP Mobile"
- BCC Program guidelines: http://archive.cancernm.org/bcc/services.html
## Family Planning Program Abnormal Cytology Test Algorithm

Always review the client’s cytology history (past results)

<table>
<thead>
<tr>
<th>RESULTS</th>
<th>NEXT CERVICAL CYTOLOGY/ACTION</th>
<th>NEXT CERVICAL CYTOLOGY/ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>UNSATISFACTORY</td>
<td>Repeat in 2-4 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Colpo is recommended if 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>consecutive unsatisfactory</td>
</tr>
<tr>
<td></td>
<td></td>
<td>results.</td>
</tr>
<tr>
<td>2</td>
<td>NEGATIVE but with absent or</td>
<td>Routine screening.</td>
</tr>
<tr>
<td></td>
<td>insufficient endocervical cells</td>
<td></td>
</tr>
<tr>
<td></td>
<td>/transformation zone component</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>NEGATIVE FOR</td>
<td>Routine screening.</td>
</tr>
<tr>
<td></td>
<td>INTRAEPITHELIAL LESION OR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>MALIGNANCY</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Organisms:</td>
<td></td>
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<tr>
<td></td>
<td>Trichomonas</td>
<td>Confirm clinically.</td>
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<tr>
<td></td>
<td>• If the woman was treated</td>
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<tr>
<td></td>
<td>when the test was taken and</td>
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<tr>
<td></td>
<td>told that her partner</td>
<td></td>
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<tr>
<td></td>
<td>needs treatment, no further</td>
<td></td>
</tr>
<tr>
<td></td>
<td>action is needed.</td>
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<tr>
<td></td>
<td>• If the woman was not treated</td>
<td></td>
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<tr>
<td></td>
<td>, consider treatment based on</td>
<td></td>
</tr>
<tr>
<td></td>
<td>the result.</td>
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<td></td>
<td>• Among women at risk for STIs,</td>
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<tr>
<td></td>
<td>screen for GC and chlamydia if</td>
<td></td>
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<tr>
<td></td>
<td>this was not already done.</td>
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<tr>
<td></td>
<td>• Explain potential</td>
<td></td>
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<tr>
<td></td>
<td>trichomoniasis complications</td>
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<tr>
<td></td>
<td>and advise STD evaluation and</td>
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<td></td>
<td>treatment for her partner.</td>
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<tr>
<td></td>
<td>Bacterial Vaginosis</td>
<td>The test is not an accurate</td>
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<tr>
<td></td>
<td></td>
<td>test for B.V. If the woman is</td>
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<tr>
<td></td>
<td></td>
<td>pregnant or trying to conceive</td>
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<tr>
<td></td>
<td></td>
<td>and her cytology is positive</td>
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<tr>
<td></td>
<td></td>
<td>for B.V, notify her and offer</td>
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<tr>
<td></td>
<td></td>
<td>other testing (pH, wet prep and</td>
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<tr>
<td></td>
<td></td>
<td>amine) prior to treatment.</td>
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<tr>
<td></td>
<td>Candida</td>
<td>If the woman is symptomatic</td>
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<td></td>
<td></td>
<td>and was not treated, consider</td>
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<tr>
<td></td>
<td></td>
<td>treatment.</td>
</tr>
<tr>
<td></td>
<td>Actinomycetes</td>
<td>See IUD in Section 2 for</td>
</tr>
<tr>
<td></td>
<td></td>
<td>management.</td>
</tr>
<tr>
<td></td>
<td>Herpes Simplex Virus</td>
<td>If woman is aware of HSV</td>
</tr>
<tr>
<td></td>
<td></td>
<td>infection, no immediate follow</td>
</tr>
<tr>
<td></td>
<td></td>
<td>up needed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If she is not aware, contact</td>
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<tr>
<td></td>
<td></td>
<td>for education and resources.</td>
</tr>
<tr>
<td>RESULTS</td>
<td>NEXT CERVICAL CYTOLOGY/ACTION</td>
<td>NEXT CERVICAL CYTOLOGY/ACTION</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------</td>
</tr>
<tr>
<td>4 ASC-US (Atypical Squamous Cells of Undetermined Significance)</td>
<td>21-24 yrs Cytology at 12 month intervals. If negative cytology x 2, return to routine screening.</td>
<td>At 12 months:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If ASC-US/LSIL, repeat cytology in 12 months (i.e. at 24 months).</td>
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<tr>
<td></td>
<td></td>
<td>• If ASC-H, AGC or HSIL, colpo.</td>
</tr>
<tr>
<td></td>
<td><strong>At 24 months:</strong></td>
<td>• If negative and the previous cytology was ASC-US/LSIL, repeat cytology at 12 month intervals until negative x 2 (e.g. at 24 and 36 months) before returning to routine screening.</td>
</tr>
<tr>
<td></td>
<td>25 yrs and older</td>
<td>• If ≥ASC-US, colpo.</td>
</tr>
<tr>
<td></td>
<td>Cytology at 12 months. If negative cytology, routine screening.</td>
<td></td>
</tr>
<tr>
<td>5 LSIL (Low Grade Squamous Intraepithelial Lesion encompassing HPV) Mild dysplasia</td>
<td>21-24 yrs Cytology at 12 month intervals. If negative cytology x 2, return to routine screening.</td>
<td>At 12 months:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If ASC-US/LSIL, repeat cytology in 12 months (i.e. at 24 months).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• If ASC-H, AGC or HSIL, colpo.</td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>At 24 months:</strong></td>
</tr>
<tr>
<td></td>
<td>25 yrs and older</td>
<td>• If negative and the previous cytology was ASC-US/LSIL, repeat cytology at 12 month intervals until negative x 2 (e.g. at 24 and 36 months) before returning to routine screening.</td>
</tr>
<tr>
<td></td>
<td>Colposcopy</td>
<td>• If ≥ASC-US, colpo.</td>
</tr>
<tr>
<td>6 ASC-H cannot exclude HSIL</td>
<td>Colposcopy</td>
<td></td>
</tr>
<tr>
<td>7 HSIL (High Grade Squamous Intraepithelial Lesion) Moderate dysplasia</td>
<td>Colposcopy</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 AGC (Atypical glandular cells) NOS, favor neoplasia, AIS (endocervico adeno carcinoma in situ)</td>
<td>Colposcopy with endocervical sampling, and endometrial sampling if ≥35 yrs or at risk for endometrial neoplasia.</td>
<td></td>
</tr>
<tr>
<td>9 Atypical endometrial cells</td>
<td>Refer for endometrial &amp; endocervical sampling</td>
<td>If no endometrial pathology, refer for colposcopy</td>
</tr>
<tr>
<td>10 Squamous cell cancer, Adenocarcinoma, Grossly malignant lesion</td>
<td>Refer to Gyn-Oncologist immediately</td>
<td></td>
</tr>
</tbody>
</table>
**INTERPRETATION AND MANAGEMENT**

Clinician must review all abnormal cytology test and unsatisfactory test results as soon as possible.

**4.4 PROCEDURE FOR CONTACTING FAMILY PLANNING CLIENTS**

This procedure is to be used when clinic staff has to contact a client to prevent adverse health outcomes if not addressed. The next steps use the framework of abnormal cytology follow up but can also be used for other notification such as positive/abnormal test results or medication recall.

**Staff Roles**

1. The nurse in charge of family planning in the clinic/PHO is responsible for the follow-up of all cytology tests. The clinician will determine appropriate follow-up based on the cytology report, clinical findings, and the woman’s ability to follow-up. The following procedure is recommended:

   - In the PHO, cytology results will be tasked to the clinician that collected the specimen. Except in rare situations where the ordering clinician is not available, the clinician who performed the test should review the cytological findings, and ‘verify’ the results. A progress note should then be created outlining the findings and plan (including treatment, if applicable, and referral or follow-up), and the note tasked for review by the PHN.

   - In the FP provider agreement clinics, the Nurse will forward cytology results to the Family Planning clinic Physician, CNP, CNM, or PA. The clinician who performed the test should review the cytological findings.

   This should be accomplished as promptly as possible and should never exceed 2 weeks from the time the result was reported. Any client with HSIL or invasive cancer is to be referred to a gynecologist as soon as possible, and this includes prompt notification of the result to the clinician. In no case should the clinician’s notification of HSIL or invasive cancer result be delayed > 1 week. Reasons for exceptions to this must be recorded on the client's record.


3. Using the client’s preferred contact information; the nurse telephones or sends a letter to all clients with abnormal cytology results **that do not require referral out of the FP clinic (e.g., ASCUS)**. All attempts should be made to discreetly contact clients requesting "no mail" through whatever means appropriate without breaching confidentiality.

   a. Record the abnormal cytology test result as an active problem in the client's record.

   b. A note is made in client's record regarding the method of attempted contact and recommendations given.

   c. The nurse will list the client on the abnormal test log (or card file), which is to be the record of clinic follow-up.

4. When the client returns to clinic, provide education about the abnormal cytology or any other condition requiring referral. **For clients who are referred out of the FP clinic,**

   a. The client should sign the “Client Acknowledgment of Abnormal Medical Condition” form included in following pages, which should be filed in the client’s record. If a client refuses treatment or referral for treatments, document client’s refusal in the record.

   b. The Referral Form should be sent to the physician or clinic along with a copy of the abnormal cytology test result(s). All HIPAA rules regarding release of client medical information must be followed.
c. Refer clients needing colposcopy to the B&CCP if appropriate using the B&CC Program Manual for questions regarding eligibility criteria. You may also contact your Region B&CCP Nurse Coordinator or call 505-841-5860.

d. After referring a client to an outside provider, the nurse should document in the client’s record that follow-up occurred before closing the case.

5. Once the recommended number of normal cytology test(s) has been obtained, the “abnormal cytology test result” problem is “resolved.” Indicate this on the client’s record and the abnormal test log (or card file). A repeat episode of an abnormal cytology test at a later date is to be given a new entry.

6. If the client does not respond or return to pick up referral paperwork, she should be contacted a second time within 2 weeks, and third time within 2 weeks after the second attempt. Document all three attempts made in the record and on the abnormal test log (or card file).

7. In case of HSIL or invasive cancer, every effort should be made to locate the client. In addition to a telephone call, all letters sent to clients should be certified letters. The return receipt (or a copy of) should be placed in client’s record. If the previous three attempts were unsuccessful within 8 weeks after cytology test result was received, consider a home visit from the nurse or other authorized staff.

8. If a client’s record lacks returned cytology results for more than 30 days, the nurse should contact the Lab for results and a copy of the report. The test should be repeated if results are not found within 2 weeks.

Clinics that cannot meet this standard need to present the problem in writing to the Family Planning Program.

REFFERAL FORM:


The following information must be included:

1. On the “Clients Name” line, add Medicaid or private insurance coverage.

2. Please evaluate the client for: (Reason for referral)

   Example: “For colposcopy – cervical cytology test of ___(date)___, results (_______).
   Previous abnormal (if any):
   (date), (results), (treatment if any___).

3. Attach copies of all abnormal results

4. From Referral Source: request for information to be returned to us on:

   - colposcopy findings
   - biopsy/pathology report
   - treatment
   - surgery
   - recommended follow-up (orders must be signed by Colposcopist)

The information from the above records and forms can be utilized for documentation and follow-up in the abnormal test log (or card file).
Client Acknowledgment of Abnormal Medical Condition

I acknowledge that I have been told by the Health Department that I have a medical condition called ___________________________ that requires medical treatment. This service is not provided by the Health Department. I understand I must go see a private physician as soon as possible. The Health Department has given me a list of doctors in my area who handle my kind of medical problem.

______________________________________   _________________________
Client's Signature       Date

Documento firmado por el/la cliente mediante el cual reconoce que adolece de una problema de salud anormal

Por la presente reconozco que el personal del Departamento de Salud de Nuevo México me ha dicho que adolecno de una enfermedad identificada con el nombre ___________________________ que requiere tratamiento por un médico. El Departamento de Salud de Nuevo México no provee ese tratamiento. Entiendo que tan pronto como sea posible tendré que consultar a un médico particular. El personal del Departamento de Salud de Nuevo México me proporcionó una lista de médicos particulares que tienen sus consultorios en la zona donde yo vivo que proveen tratamiento para el tipo de enfermedad identificada más arriba.

______________________________________   _________________________
Firma del/la cliente       Fecha
### 4.5 VAGINITIS: DIFFERENTIAL DIAGNOSIS FOR CLINICIANS

<table>
<thead>
<tr>
<th></th>
<th>NORMAL</th>
<th>BACTERIAL VAGINOSIS</th>
<th>CANDIDIASIS</th>
<th>TRICHOMONIASIS</th>
<th>ATROPHIC VAGINITIS</th>
<th>CHEMICAL OR ALLERGIC VAGINITIS</th>
<th>LACTOBAČ ILLOSIS</th>
<th>CYTOLYTIC VAGINITIS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Color of discharge</strong></td>
<td>Slate gray/White/Clear</td>
<td>Gray/White</td>
<td>White/Yellow</td>
<td>Yellow-green/Green/Gray/Yellow</td>
<td>Gray/Yellow</td>
<td>Normal</td>
<td>White</td>
<td>White</td>
</tr>
<tr>
<td><strong>Odor of discharge</strong></td>
<td>Normal body odor</td>
<td>Fishy</td>
<td>None/Yeasty/Musty</td>
<td>Foul</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
<td>Normal</td>
</tr>
<tr>
<td><strong>Consistency of discharge</strong></td>
<td>Thin homogeneous Mucoid</td>
<td>Thick plaques, may be adherent to vaginal walls/Creamy/Thin, watery</td>
<td>Thin/Frothy/May be non-frothy</td>
<td>Watery homogeneous/Purulent/Serosanguinous/Sticky</td>
<td>Normal</td>
<td>Pasty</td>
<td>Pasty</td>
<td></td>
</tr>
<tr>
<td><strong>Presenting complaints</strong></td>
<td>None</td>
<td>Odor, increased discharge, minimal or no pruritus, occasional irritation</td>
<td>Pruritus, burning, dyspareunia, external dysuria, increased discharge or dryness</td>
<td>Pruritus, burning, dyspareunia, external dysuria, increased discharge</td>
<td>Spotting, burning, dyspareunia, pruritis, external dysuria, increased discharge</td>
<td>Pruritis, tenderness/pain, burning, external dysuria, dyspareunia</td>
<td>Pruritis, dyspareunia, vulvar dysuria and cyclic increase in symptoms</td>
<td></td>
</tr>
<tr>
<td><strong>Physical findings</strong></td>
<td>Absence of abnormality</td>
<td>Absence of inflammation, Pooling of discharge at introitus, <em>Positive whiff.</em></td>
<td>Erythema of vulva, vagina; Excoriations secondary to scratching; Possible tissue friability.</td>
<td>Erythema; Petechiae especially of cervix; Cervical friability, Occasional lower abdominal pain, inguinal lymphadenopathy</td>
<td>Pale, pink vaginal, cervical mucosa/absence of rugation Sparse, brittle pubic hair; Inflammation; Ecchymosis; Petechiae; Excoriation</td>
<td>Erythema; Edema; Vesicles or blisters; Oozing; Ulcerations Thickened skin, white patches, lymphadenopathy</td>
<td>Erythema Edema Normal</td>
<td>Erythema Edema Normal</td>
</tr>
<tr>
<td><strong>pH</strong></td>
<td>≤ 4.5</td>
<td>*≥ 4.5</td>
<td>≤ 4.5 or slightly ↑</td>
<td>5.2-7.0</td>
<td>5.5-7.0</td>
<td>≤ 4.5</td>
<td>3.6-4.7</td>
<td>3.6-4.7</td>
</tr>
<tr>
<td></td>
<td>NORMAL</td>
<td>BACTERIAL VAGINOSIS</td>
<td>CANDIDIASIS</td>
<td>TRICHOMONIASIS</td>
<td>ATROPHIC VAGINITIS</td>
<td>CHEMICAL OR ALLERGIC VAGINITIS</td>
<td>LACTOBACILOSIS</td>
<td>CYTOLYTIC VAGINITIS</td>
</tr>
<tr>
<td>-------------------------</td>
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</tr>
<tr>
<td>Microscopic findings</td>
<td>Squamous epithelial cells; Lactobacilli; Few WBCs</td>
<td>Rare WBCs; *Clue cells, Decreased lactobacilli, Increased bacteria, especially thin, curved, crescent-shaped rods</td>
<td>Pseudohyphae; Yeast buds; WBCs Lactobacilli</td>
<td>Motile trichomonads with flagellae/WBCs</td>
<td>Decreased lactobacilli; Increased WBCs and bacteria/RBCs; Absence of pathogens; Increased number of parabasal cells on maturation index</td>
<td>Absence of pathogens/WBCs</td>
<td>Lactobacilli are 6 times longer than normal. No fungi. Few WBCs</td>
<td>Evidence of cytolysis with bare intermediate nuclei; overgrowth of lactobacilli, often adherent to epithelial cells</td>
</tr>
<tr>
<td>Relationship of symptoms to menses</td>
<td>Increases around ovulation</td>
<td>Not applicable</td>
<td>Increased before menses. Relief with after menses</td>
<td>Increased during, after menses</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td>Increased before menses</td>
<td>Increased before menses</td>
</tr>
<tr>
<td>Treatment</td>
<td>None</td>
<td>3 out of 4 * criteria should be present before treatment.</td>
<td>Clotrimazole Cream OTC 1applicator Per vagina at bedtime for 7 days OR Fluconazole by prescription 150 mg by mouth, as one time dose</td>
<td>Metronidazole 2 gms by mouth as one time dose. Partner needs treatment</td>
<td>Consider prescription for Estrogen Cream or refer to PMD to consider HRT</td>
<td>Remove culprit</td>
<td>Amoxicillin and Clavulanate by prescription 500mg by mouth three times a day for 7 days*</td>
<td>Doxycycline by prescription 100 mg by mouth twice a day for 7 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Metronidazole 500 mg by mouth, twice a day for 7 days</td>
<td>D/C tampon use until symptom free for 6 months</td>
<td>Sodium Bicarbonate sitz baths 1 - 2 TBSP to 1 liter warm water 3 times in 1 week. Then weekly until symptom free</td>
<td>OR D/C tampon use until symptom free for 6 months</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table from Gynecology-Well-women Care by Ronnie Lichtman and Susan Papera with the added columns for lactobacillosis and cytolytic vaginitis

Vaginitis Differential Diagnosis

Figure 1 Lactobacillosis

Figure 2 Cytolytic Vaginosis