Adolescent Medicine Virtual Preceptor Questions and Answers

Question:
When seeing a teenage girl with mennorrhagia who has been bleeding for more than 2 weeks what would be your choice of OCPs? Would you start her on a daily pill if her hemoglobin was normal? Would you give her a higher dose for a few days? I have used Lo/Ovral 4 pills for 4 days, 3 pills for 3 days, 2 pills for 2 days then daily pills but they get very nauseated.

Answer:
I tend to also use Lo/Ovral, but usually use 2 pills a day (can take them every 12 hours) until the bleeding stops, then 1 pill per day. Lo/Ovral is a good choice because it has a progestin with a long half-life that stabilizes the endometrium. At times, I will start with 3 pills a day if the anemia is severe. If so, then I do taper to 2 pills a day for a couple of days, then 1 pill daily.

I find that 4 pills a day makes many teens sick and the tapering schedule confuses most teenagers.

Also - make sure you tell them to pop out the last week of pills from the pack (the placebos) and throw them away, and just start a new pack when they finish the active pills of the first pack. If they take the placebos - they will probably re-bleed within 2-3 weeks of starting pills and you do not want that.

If a teen has been bleeding for 2 weeks but is not anemic, I usually offer birth control pills but do not insist - it is their choice. If they do start, depending on the intensity of bleeding, I start with either 1 or 2 pills a day. Remember - always start iron, and see them back in 2 to 5 days for a re-check.

Question:
If an adolescent comes to me the day after having unprotected sex with a partner and is worried that she might have a sexually transmitted infection, should I treat empirically? If she tests negative that day for gonorrhea, chlamydia, syphilis, and HIV, should I repeat any of those tests later as they may not have had time to turn positive?

Answer:
Public health experts would recommend treating empirically for STI's anyone who is a known STI contact, prior to the results of testing. Victims of sexual assault should also be treated empirically. If a patient is just suspicious, it is

correct to test and wait for results. However, if the exposure is within 24 hours, it is recommended to bring the patient back in 1-2 weeks to re-test, and sooner if they become symptomatic. Bacterial STI's (gonorrhea and chlamydia) can become apparent in about a week, sooner with highly sensitive nucleic acid tests. Trichomonas also shows up in about a week. For HIV and syphilis, the recommendation is to re-test in 6 weeks, then 3 months and 6 months. However, most of these infections should be detected within 90 days of initial exposure.

Question:
In a teen with a family history of early stroke, do you recommend against giving combined birth control pills or do you do a work-up prior to starting them?

Answer:
It depends if you can pin down the cause of the stroke...There are many causes of early stroke that do not preclude you giving a contraceptive method that contains estrogen, as they would not necessarily imply a familial risk of thrombosis. These include CVA's secondary to uncontrolled hypertension, hyperthyroidism, sickle cell disease, severe coronary artery disease, etc. The worrisome histories are those where a mother or sister had a CVA while on birth control pills or during or shortly after pregnancy.

If you can be satisfied that the reason for the CVA was not a familial cause of a hypercoagulable state, you can probably feel comfortable starting OCP's. If you are not sure, a thrombophilia work-up may be wise prior to starting OCP's.

Question:
How careful does one have to be in prescribing combination OCP's with patients with migraines? Does the presence of an aura make a difference?

Answer:
The problem with prescribing OCP's to women with migraine has to do with the risk of stroke. There is data that suggest that migraines and combination oral contraceptives -COC's- (birth control pills that contain estrogen) may be independent risk factors for ischemic stroke. It has also been found that migraine combined with COC use exerted a greater than multiplicative effect on risk of ischemic stroke - in women who had migraines and used COC's, there was a 2-4 fold increased risk of stroke compared to those with migraines who did not use COC's.
There is also data that suggest that women who have migraine with aura have a greater risk of stroke than those who have migraine without aura.

After evaluating this data, the World Health Organization has recommended the following:
For women who are less than 35 years old and have migraine without aura - the benefits of COC's generally outweigh the risks, and they can initiate COC's. If, however, migraines develop or worsen while on COC's, it is recommended that one switches to a non-estrogen-containing method.
For women with a history of migraine and aura (focal neurological signs), US product labeling states that COC use is contraindicated. WHO guidelines also state that the use of COC's in women with migraine and aura poses an unacceptable health risk (Category 4).

Question:
I recently saw an 18 year old patient who admitted to IV heroin use and presented for a GYN exam/STD/HIV testing. She refused inpatient or outpatient rehab. What is our obligation to this patient/would there be grounds for admitting her against her will?

Answer:
Our obligation is to give her the best care we can, that she desires. Which would mean general and reproductive health care, STI and HIV screening (if she chooses this), and counseling about all her risky behaviors. And hopefully, we can engender a rapport with her so that she will return, and eventually work with us to understand the dangers of her behaviors.

However, she is 18 and considered an adult, and, as such, is responsible for her own behaviors. If you feel that she is an immediate danger to herself, you can obtain a mental health consult, but an involuntary admission (to a medical floor? to a psychiatric hospital?) would be difficult and probably not very constructive.

Question:
While it is clear to me that adolescents have the right to complete confidentiality with regard to reproductive health care, the limits on confidentiality with regard to alcohol and drug use is much less clear to me. If a patient discloses drug or alcohol abuse to a physician- does the doctor have a responsibility to report the abuse to a parent? Can the patient request confidentiality with regard to the disclosure of alcohol/drug use? If a parent wants to know if their teen is using drugs or alcohol, does the physician need to answer them? What if the parent demands that their child be tested for drugs-do you need the patient's consent to check urine toxicology?

Answer:

Disclosure by an adolescent patient of drug or alcohol use to a medical provider does not mandate reporting to a parent. In fact, confidentiality should be maintained unless the provider deems that the use of such substances constitutes a major danger to the patient or to others (that is how we always preface promises of confidentiality). If the provider feels that the child is in danger, he/she should discuss with the patient whether the parents suspect/know, and then how to best involve them so that treatment can be accessed and safety can be assured.

With respect to treatment for substance abuse - according to the New York Civil Liberties Union Teen Health Initiative:

"Regarding Drug and Alcohol Counseling Services:

Parental consent is not required for a minor to receive drug and alcohol counseling (without medication). In order for a minor to receive medical drug and alcohol treatment without parental involvement, a physician or nurse would have to determine that a parent's knowledge of the treatment would have a negative effect on the minor, or the minor's parents must have refused to consent to the treatment and a physician determines that treatment is in the minor's best interests."

Finally, with respect to drug testing, the AAP does not endorse involuntary drug testing in a competent teen without the teen's knowledge and consent. If the teen is incapacitated - i.e. with altered mental status or inability to make decisions, then a medical provider can test. So - no secret drug tests in a competent teen with decision-making abilities.

Hope this helps - this may seem like a muddy issue, but is often easily resolved if you think it through and remember to keep the best interest of the patient as your goal.

Question:
The other day in clinic, the mom of a patient came in to ask me if her daughter had been pregnant. A few weeks prior, the daughter came in and had a pregnancy test, which was positive, and this is all documented in my note from that visit. Does the parent have the right to the chart? If, for example, they were transferring care and wanted a copy of the medical record, what happens to that information? We have to keep records for ourselves in the chart-- who can see these records and, if the parents can, is there a different place we should be writing confidential information?

Answer:

First - in most states, including New York, adolescents have the right to consent on their own for reproductive health care (STI diagnosis and treatment, contraception, pregnancy testing, and in NY, abortions), and are ensured confidentiality regarding such services if requested.

With respect to the medical record, in NY, the parent or guardian is not entitled to inspect or make copies of any patient information regarding the care or treatment of the minor if the health care provider determines that granting access would be detrimental to the provider's professional relationship with the minor, or on the care and treatment of the minor, or on the minor's relationship with the parent.

HIPAA complicates matters. The HIPAA Privacy Rule creates new rights for individuals to have access to their protected health information, and to control disclosure. In general, when minors legally consent to health care or can receive it without parental consent, or when a parent has assented to the agreement of confidentiality between the minor and the health care provider, the parent does not necessarily have the right to access the minor's information. State, or other laws which regulate such disclosures, are controlling (from "State Minor Consent Laws, A Summary" by English and Kennedy).

So - in this case, I would not break confidentiality verbally, and if the parent requested the record, depending on the circumstances, I would withhold aspects of the visit that, if divulged, would break confidentiality.

However, it is often helpful to ask the parent "Why are you concerned? What has your daughter already told you?" Often, the parent already knows the truth, but does not know how to talk to her child about it. A good health care provider can sometimes enhance parent child communication without breaking confidentiality.

Question:
As part of my psychosocial exam, I often ask sexually active patients the age of their partner. From a legal and from an ethical standpoint (which may or may not be the same here), what should we do if there is a significant age gap that would classify the sexual activity as statutory rape (e.g. 15 year old girl and a 24 year-old guy)? Are there reporting requirements? Does it matter if the parents condone it? At what point (age gap) might your answer change?

Answer:
Excellent question - and one that I'm surprised is not asked more frequently! The answer is complicated - legally, the definition of statutory rape varies

from state to state, as do the reporting responsibilities. I will only talk about New York State. I'm also going to quote from and refer you to the New York Civil Liberties Union website. and the Go Ask Alice website at Columbia University, for more information.

First - the definition of statutory rape in NY is as follows, and quite complicated:

(Taken from the Go Ask Alice website):

"According to Article 130 (Sexual Offenses) of the New York Penal Code, if the perpetrator is less than 21 years of age and the victim is under 17 years, this is a sexual misconduct offense; if the perpetrator is older than 21 and the victim is under 17, this is known as third degree rape; if the perpetrator is older than 18 and the victim is less than 14, then this is second degree rape; and, if the victim is younger than 11 years of age, then first degree rape has been committed.

The severity of the punishment varies according to the charge. In New York State, sexual misconduct is a Class A Misdemeanor, which carries a maximum sentence of 1 year; third degree rape is a Class E Felony, with a maximum sentence range of 3 - 4 years; second degree rape is a Class D Felony, with a maximum sentence range of 3 - 7 years; and, first degree rape is a Class B Felony, with a maximum sentence range of 6 - 25 years. Of course, sentencing also depends on multiple variables of each individual case and therefore, may or may not follow these sentencing guidelines."

So - your scenario can potentially be prosecuted as a Class E Felony. However, although the law does not recognize that a teen under the age of 17 can give consent for sexual activity, I think we can say that as medical providers, we certainly see otherwise.

Now let's talk about mandatory reporting. Medical providers are mandated reporters if they suspect child abuse - there is no law that requires mandatory reporting by medical providers if they suspect statutory rape. So, are the parents responsible for stopping the relationship?

From the NYCLU website, now:

"Should a mandatory reporter report the parents of a sexually active minor to the State Central Register solely on the basis of her sexual activity with an older boyfriend?

NO. In order to report a possible case of child abuse or neglect, a mandatory reporter must have a reasonable suspicion that such abuse or neglect is occurring.24 Because the failure to prevent a child's voluntary sexual activity does not constitute abuse under New York law, this situation in and of itself cannot give rise to a reasonable suspicion of child abuse. Therefore, without other evidence of abuse, mandatory reporters may not report sexually active or pregnant minors to the State Central Register. Such a report, without other evidence of abuse, would be a false report, subjecting the reporter to criminal and civil liability.25 Furthermore, when a mandatory reporter is a health care provider or other professional with confidentiality obligations, making a report where there is no reasonable suspicion of abuse constitutes professional misconduct and may subject the provider to professional sanctions for breaching a patient's confidentiality.26 Similarly, health care, educational and other facilities may not impose policies requiring the blanket reporting of all sexually active or pregnant teens to the State Central Register as such situations generally will not involve child abuse.

Note that even though the minor may be the victim of a statutory sex offense, no New York law requires the reporting of crimes.27 Furthermore, in the context of health care provision, reporting any crime without the patient's prior permission breaches patient confidentiality and constitutes professional misconduct.28

It is important to remember, however, that where the teenager is having sexual relations with a family member, where the sex is forced and parents have knowledge and do not intervene, or where there is evidence of parental abuse other than the mere fact of a teenager's sexual activity, this rule would not apply."

These last 2 paragraphs may answer your question. There is no law in NY that requires reporting of crimes (even though the relationship may fit the formal statutory rape guidelines). And you can only report the parents if you clearly suspect abuse or neglect. For example, if the child is very young or mentally incapacitated, I would consider a relationship with an older man child abuse, and involve the family; if they seem to condone a clearly abusive relationship, I may report them.

In summary, medical providers in NY have no legal responsibility to report older partners in consensual relationships. However, ethically, I do think there are times to involve either the family or a social worker...

Question:

When evaluating a developmentally delayed teen, or pre-teen, when and how do you begin to talk to the parents about contraception? Have you ever had to speak about sterilization to protect the child?

Answer:
Generally, around the time of menarche, I discuss menstrual hygiene, reproductive capability, and the potential for abuse. I ask the parent (and the patient, depending on the degree of delay) to let me know if there are concerns and if hormonal contraception would make sense for them in the future. If there are no contraindications to estrogen, use of birth control pills is an option both for menstrual control and contraception; Depo-Provera is almost always an option for such teens. Often, families like to hear that there are options, but are not interested in starting something right away. However, I do encourage contraception for teens with milder delay and poor judgment, or for those about whom there is concern that sexual activity may take place.

Because there are so many highly effective methods of reversible hormonal contraception available, I never recommend sterilization for teens. In NY, anyhow, one must be 21 for tubal ligation, and even then, for impaired adults, if there is an issue of lack of informed consent, an ethics committee should be involved prior to sterilization.

Question:
Legally, does an adolescent have to be accompanied by a parent in order to receive most medical care? I know for STI/pregnancy issues, they can receive care without consent, but what about for vaccines or if they need other medications? How do you gauge the appropriateness of allowing the teen to come alone?

Answer:
This is a good question - which often plagues general pediatricians as well as adolescent medicine providers. In general, patients below the age of 18 should have parental permission for treatment except in the cases of:

-Reproductive health care, including STI testing and treatment, pregnancy testing, HIV testing, and routine and emergency contraception. In these cases, care does not require parental consent and strict confidentiality is maintained. Laws regarding abortion vary by state, and in NY, patients can undergo abortions without parental notification or consent.

-Prenatal care (a pregnant minor can receive parental care without parental involvement).

-Emancipated minor, which is defined in this state as a child under the age of 18 who is either married, a parent, economically independent of the parent, or in the armed forces.

-Emergent care, in which case the parent should be informed of treatment at the earliest opportunity.

-Certain mental health services and substance abuse evaluations, and at times, even treatment, can be rendered without parental knowledge or consent.

In cases in which the provider knows the parent and the parent has agreed to treatment in his or her absence, the provider may treat the patient but should update the parent regarding treatment at a convenient time. This often happens in private practices, and in our adolescent clinic, when teens are sent to the provider by a parent for evaluation, immunizations, etc.

There exists a circumstance in which a medical provider can render general health care (non-reproductive) in good faith to an adolescent between the ages of 14 and 18, when the teen consents to care. We call this "the mature minor" scenario. The definition of a mature minor is looser than that of an emancipated minor, but basically applies to any child over the age of 14 who shows understanding of his/her illness and treatment options. In general, case law has supported the medical provider in such circumstances, but it is murkier.

Now, to answer your question - if I know the adolescent and his/her parent, and there is opportunity to communicate with the parent, I may see a child as young as 12 or 13 alone. It all depends on the maturity of the child and the service requested.

Question:
When doing a wet prep (in the rare clinic with a microscope), at what power of magnification do you expect to see motile trichomonas organisms - 4x?10x? 40X? And what is the best way to do a wet prep in the office?

Answer:
I do a wet prep by taking a cotton or Dacron swab from the vagina and then putting it in a plastic UA tube, with about a half inch of normal saline. I then bring it to the microscope, dab the solution on a slide, and cover it with a glass cover slip.

Trichomonas is best seen under 40 power. Trichomonads tend to be a little bigger than white cells and globular, with tiny hair-like flagellae. The wet

prep often also shows many white cells, along with the trich. Although trichomonads are usually motile, you may not see them move; instead you sometimes see just the flagella move. Of note, studies show that microscopy of vaginal secretions is only about 60-70% sensitive.

Question:
While in the E.D. I treated a teenager who had consensual sex with a known partner but the condom broke. The partner had multiple sexual partners in the past and refused to disclose if he had any sexually transmitted diseases. She requested HIV prophylaxis. Do you normally provide HIV, STD, pregnancy prophylaxis to patients in this type of situation?

Answer:
This is a good question - and one that I am surprised has not come up more often.

First, the easy part: Any female who has experienced a broken condom (or any unprotected intercourse) who presents within 5 days should be offered emergency contraception (EC). We do know that the sooner it is initiated after unprotected intercourse, the greater the efficacy. I prescribe or dispense Plan B (levonorgestrel) – it now comes in a single pill called One-Step and is covered by Medicaid and most private insurance plans,.

As far as routine STI prophylaxis in cases of unprotected sex, it depends on the situation. Certainly, in cases of rape or sexual assault, we recommend it. In cases of consensual sex, if the partner is known to have an STI (or rumored to have one...), I would also treat empirically for chlamydia and gonorrhea. However, the young women should also be screened for STI's at that time, and scheduled for a contraceptive and follow-up visit.

Now, for the hard part...HIV post-exposure prophylaxis (PEP) in non-occupational settings should certainly be offered in cases of sexual assault. The regimen must be initiated within 24 hours, and is usually continued for 4 weeks. There is significant potential toxicity (hepatotoxicity, anemia, pancreatitis). We usually do not encourage it in cases of consensual sex with a broken condom, but I can see that in certain situations, it might be advisable (unprotected sex with a known HIV-positive partner, or an IV drug abuser...). If the patient presents within 24 hours, and requests HIV prophylaxis, her risks should be carefully assessed, and a thorough discussion of the risks and benefits of the medication should take place. It is quite expensive, as well, and not always covered by all insurance plans. If PEP is initiated, the patient should be given an appointment for one week

later to discuss again, in a less pressured environment, the risks, benefits, and side effects, and a decision can then be made whether to continue with the regimen.

As a rule, most patients who have presented to me after unprotected sex usually request STI screening and emergency contraception only. The request for HIV PEP, I believe, depends on the patient's perception of her risk.