What am I?

“I am sick. I have severe stomach cramps, I am bleeding, I have back pain and diarrhoea”

Sophie Hagen

I'm done saying "I'm on my period" because I don't think it means anything to men, in particular. Instead, I will be saying: "I am sick. I have severe stomach cramps, I am bleeding, I have back pain and diarrhoea"

Women's Health

Dr Seb Pillon

GP ST2

Women in Medicine

- In 1865, Elizabeth Garrett Anderson became the first woman in Britain to qualify as a physician and surgeon. No hospitals would admit her as a Doctor, including Westminster – the then Chair of Medicine Dr Basham had denied her entry to study at the Hospital school in 1861.
- Her life was one of many pioneering firsts, including becoming the first female Mayor, the first female Dean of a medical school, and the first woman to ever sit on a school board of governors in Britain.
- Her example went a long way to liberalising admission policy at medical schools across the country: in 1876, partly due to Elizabeth's open campaigning, an act was passed forcing the British Medical Register to accept women.
- By 1914, there were over 1000 female doctors in England.

Dr Edward H. Clark published his book ‘Sex in Education’ in 1873 in which he argued:

“higher education in women produces monstrous brains & puny bodies, abnormally active cerebration & abnormally weak digestion, flowing thought & constipated bowels”

Women in Medicine

Women in Medicine

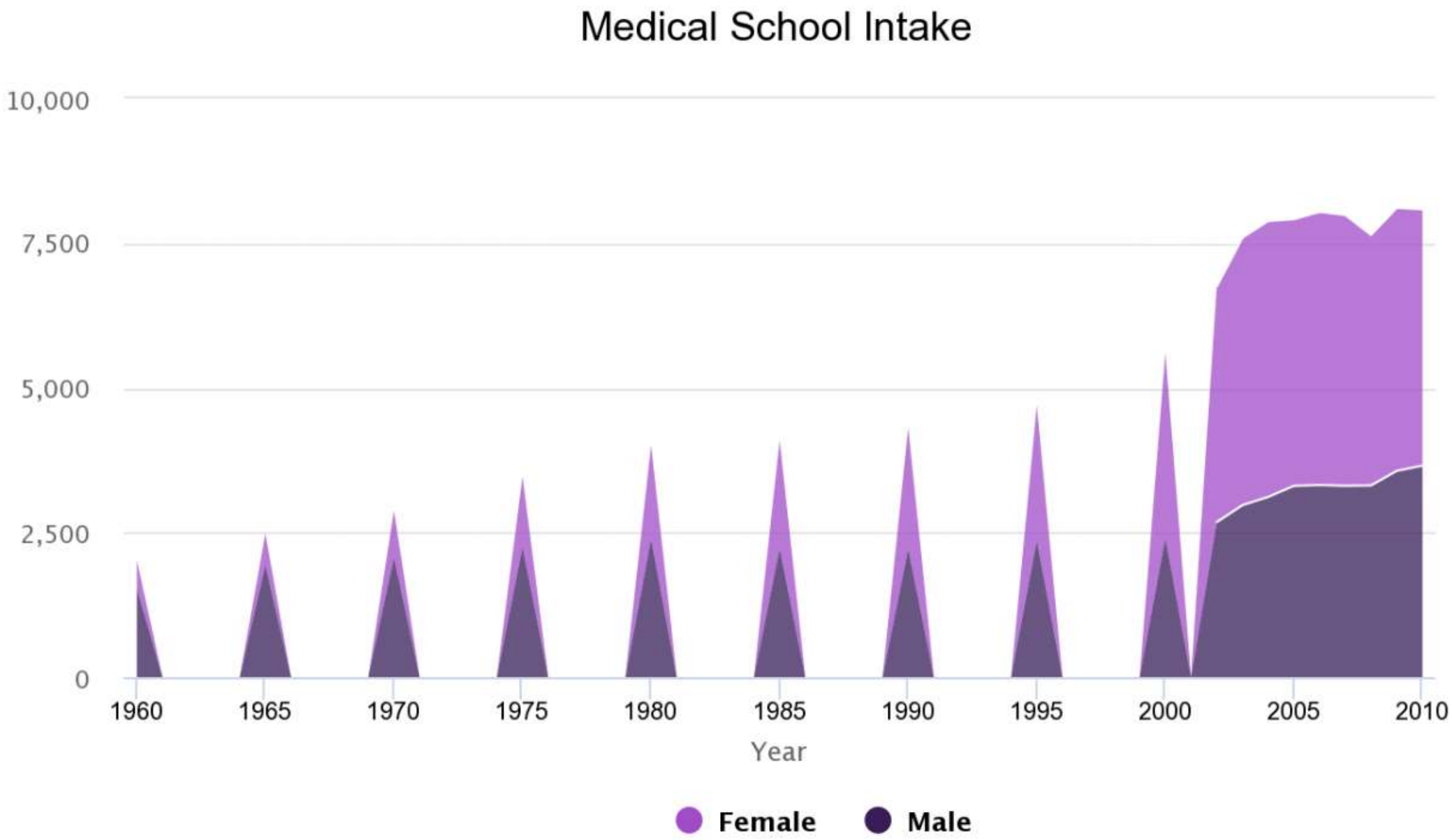
Elizabeth Blackwell
First female physician in USA (1849)

Mary Jacobi
First female graduate of l'École de Médecine in Paris (1864)

Metrodora (c. 200–400 CE), a Greek physician, wrote the oldest medical text known to have been penned by a woman. Among many other innovations, she pioneered surgical treatments for breast & uterine cancers.

The Westminster Review of 1868:

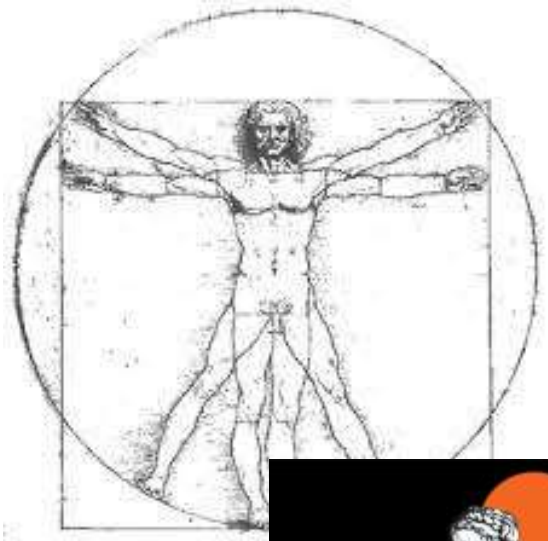
"Men have never made an outcry against women's entering upon any occupation however hard or "degrading," unless that occupation were one in which they would compete with men! "

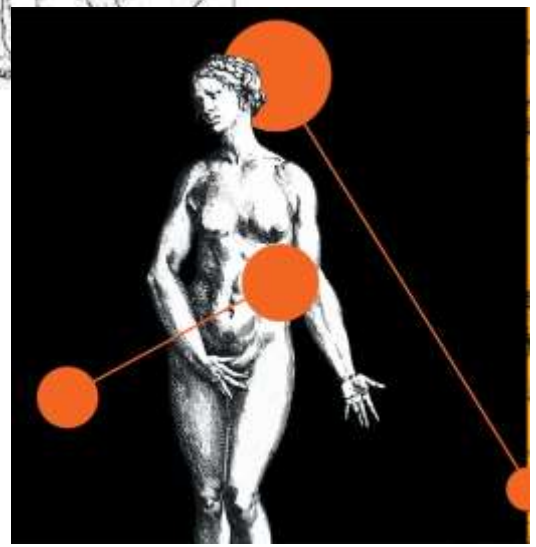

Medical School Intake
10,000
7,500
5,000
2,500
0
1960
1965
1970
1975
1980
1985
1990
1995
2000
2005
2010
Year
Female
Male

Medical Sexism

- **91%** of women respondents had experienced sexism at work within the past two years
- **74%** of all respondents think that sexism acts as a barrier to career progression
    - **42%** of all respondents who witnessed or experienced an issue relating to sexism in the past two years chose not to raise it with anyone
- **70%** of women respondents felt that their clinical ability had been doubted or undervalued because of their gender, in comparison to 12% of men.
- **31%** of women respondents experienced unwanted physical conduct in the workplace as did 23% of men respondents
- **56%** of women respondents had received unwanted verbal conduct relating to their gender as did 28% of men respondents.

Medical Sexism

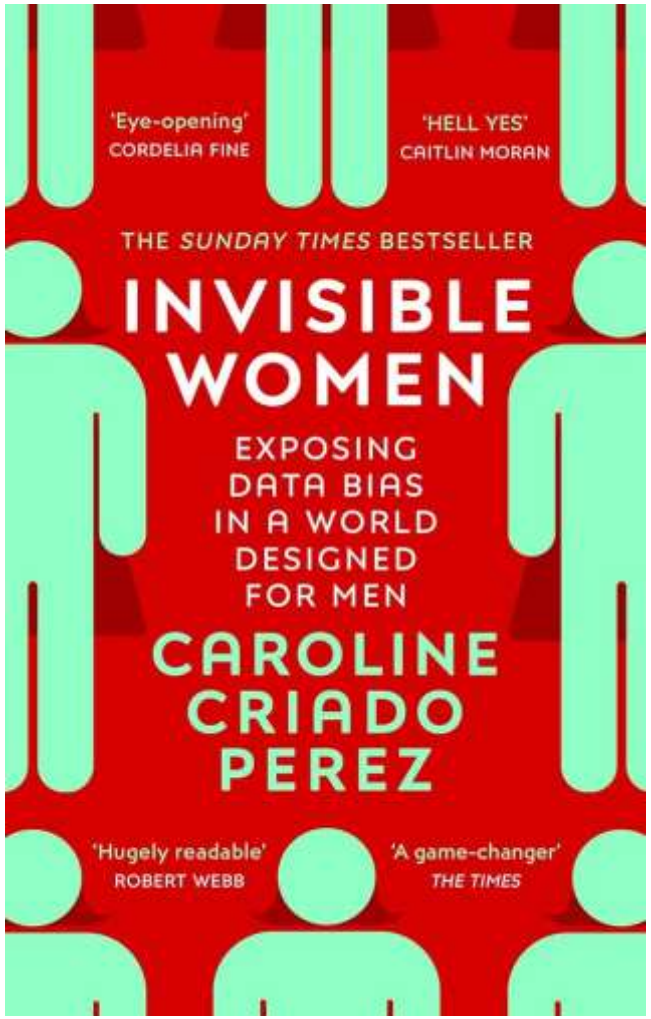




- A study of men and women who went to A&E with abdominal pain showed that women waited an average of 65 minutes to be seen by a doctor.
  - Men only waited 49 minutes.
  - Women were less likely to be given painkillers too.
- Women tend to have better verbal memories than men.
  - This means they perform better in memory tests, and so early stage Alzheimer's is less likely to be diagnosed.
- Research by Oxford University found that women are 13% less likely than men of the same age to secondary prevention after a heart attack.
  - Women are twice as likely as men to die in the 30 days after a heart attack.
- Women's bodies, and the conditions that affect them, are less likely to have been medically studied.
  - In a form of observer bias, male clinicians are more likely to study men.
  - Male lab rats are used instead of female ones.

Invisible Women

- "The result of this deeply male-dominated culture is that the male experience, the male perspective, has come to be seen as universal, while the female experience-that of half the global population, after all-is seen as, well, niche."
- "A 2008 analysis of a range of textbooks recommended by…the most prestigious universities…revealed that across 16,329 images, male bodies were used three times as often as female bodies to illustrate 'neutral body parts'."
- **"It's not always easy to convince someone a need exists, if they don't have that need themselves."**
- "How many treatments have women missed out on because they had no effect on the male cells on which they were exclusively tested?"



https://youtu.be/C6vAoD3HA9I?si=-O4yeom4ZFPt6gQb

Cases

Women’s Health

Routine consult: Period pain

Michaela, 24, has heavy & painful periods. She needs to take time off work most months and wonders if she can have a sick note.

Pain starts about a week before she is due, and is felt in her abdomen, like a cramping but it doesn't settle for hours at a time.

She has tried a gluten-free diet as she gets diarrhoea at the same time, and wondered if she was eating more bakery products as comfort food. It hasn't helped.

Sex is sometimes painful, and worrying about this is affecting her relationship.

There is sometimes blood in her urine before her period seems to start.

Things are easier after a period, but she is losing almost 2 weeks out of every month.

What diagnoses should we consider? What should we do next?

E-Consult: Requesting Clotrimazole

Franca, 68, requests Canestan Duo on prescription as it's too expensive to buy at the pharmacy (£14.99)

Gets recurrent vaginal thrush and feels itchy down below.

5th request for prescription in 12 months.

PMHx: T2DM (last HbA1c = 55), Hypertension (last BP 138/76), low back pain, osteoarthritis of knees

How will you deal with this e-consult?

Urgent Appointment: Low Mood

Emily, 32, presents with anhedonia, low motivation, tearful, poor sleep, increased anxiety (especially about being a mother). Partner worried about her as saying things like “maybe better if I had a miscarriage”

She is 18/40 pregnant (first pregnancy). Not yet had booking appointment.

Past medical history: Depression, Menorrhagia

Medication: Sertraline 100mg OD on repeat list

What do you want to know? What can you do to help?

Telephone consult: Bleeding

Saara, 25 has heavy periods each month.

Lower abdominal pain and cramping, makes feel nauseous.

Ibuprofen and hot water bottle help a bit

No intermenstrual bleeding. No post-coital bleeding. No vaginal irritation nor discharge.

Getting married this year and planning for family soon.

No current contraception.

What next?

Urgent Appointment for Abdo Pain

Angela, 57, presents in an on-the-day appointment with 6 months of abdominal pain. She describes it as “it just aches sometimes”, not now. Occurs all over abdomen. Some nausea, no vomiting, worse when she is anxious & Gaviscon seems to help.

She is post-menopausal, on citalopram 40mg OD & propranolol 40mg PRN for anxiety. She takes co-codamol 30/500 PRN for low back pain.

No vaginal bleeding. LMP >5y ago. Passes urine 9-10 times a day, 3 or 4 times at night. No change in bowel habit. No weight loss, but reduced appetite.

What else might you ask? What happens next?

Results Appointment: Feeling Tired

	16/10/19	27/4/23	5/5/23	3/1/24
Hb	109	123	118	115
MCV	80	80	79	82
MCH	28	29	28	29
D DImer	-	-	-	350
CRP	-	-	-	6
Ferritin	18	-	-	180
Vit D	-	46	-	22
eGFR	88	70	>90	81

- Sudhira, 24, is feeling exhausted and tired all the time. She is currently in her 30th week of pregnancy.
- **How would you interpret these bloods? Anything else you want to know?**

Telephone consult: New pregnancy

Asha, 31 is newly pregnant, maybe 6-7 weeks based on LMP & 3 x positive urine βHCG

She is passing urine more frequently; her breasts feel sore. She is finding herself cry more easily and worried she has "postnatal depression". Her appetite has increased, and she is more tired, finding herself wanting to nap most days.

She has no past medical problems or current medication. She is taking a multivitamin and drinking more water.

What's wrong? What advice do you need to give?

On-the-day consult: Breast lump

Nadia, 19, has a new breast lump, noticed this morning in shower.

No family history of breast cancer, ovarian cancer or pancreatic cancer

LMP 2 weeks ago.

On examination: firm, non-tender, highly mobile palpable lump to outer quadrant of left breast, no axillary lymph nodes

What should we do? What do we explain to Nadia?

Conditions

Heavy Menstrual Bleeding

Sarah Millican

https://youtu.be/S3Dkkcfe254?si=r9Rs7Pdiwtx3dn9n

Heavy Menstrual Bleeding (HMB)

- Heavy menstrual bleeding is common
  - 20% women experience heavy periods with 5% women aged 30-49 presenting to primary care each year.
- HMB affects a woman's physical, psychological and social health and wellbeing.
- HMB occurring in women with obesity or any condition causing unopposed oestrogen excess requires investigation to exclude endometrial hyperplasia and cancer
- Treat without further need to examine or investigate if there are no additional symptoms and low risk for endometrial pathology.

Heavy Menstrual Bleeding (HMB)

- Pelvic ultrasound scan (trans-vaginal preferably) for possible larger fibroids or adenomyosis:
  - Enlarged uterus/ pelvic mass/ pelvic pressure symptoms
  - Dysmenorrhea
- Hysteroscopy for possible endometrial pathology (hyperplasia/polyps/submucosal fibroids), e.g. persistent irregular and/or intermenstrual bleeding:
  - Infrequent heavy bleeding plus obesity or PCOS
  - Late menopause (over 55)
  - Use of tamoxifen
  - FH Breast/bowel/ovary cancer
  - Abnormal ultrasound scan findings
  - If previous treatment unsuccessful
- Treat with tranexamic acid +/- analgesia at first visit, including while waiting for further investigations or referral.

Heavy Menstrual Bleeding (HMB)

- **Hormonal:**
  - Levonorgestrel intra-uterine system
  - Combined hormonal contraception
  - Long-cycle or continuous progestogens
- **Non-hormonal:**
  - Tranexamic acid (1.5g three or four times daily)
  - and/or NSAID of choice
- **Surgery referral:**
  - Fibroid resection or embolization
  - Endometrial ablation
  - Hysterectomy

Endometriosis

Endometriosis

- Suspect when patients have 1 or more:
  - Chronic pelvic pain (defined as a minimum of 6 months of cyclical or continuous pain).
  - Period-related pain (dysmenorrhoea) affecting daily activities and quality of life.
  - Deep pain during or after sexual intercourse.
  - Period-related or cyclical gastrointestinal symptoms, in particular painful bowel movements.
  - Period-related or cyclical urinary symptoms, in particular blood in the urine or pain passing urine.

Endometriosis: Differential Diagnoses

- Uterine conditions
  - Adenomyosis
  - Fibroids
- Urological conditions
  - Interstitial cystitis
  - Recurrent UTI
- Gastrointestinal conditions
  - IBS
  - Gastroenteritis
  - Appendicitis
  - Coeliac disease
- Gynaecological
  - Pelvic Inflammatory Disease
  - Ovarian cyst
    - Take care not to over-attribute pain to normal benign cysts
  - Pregnancy
- MSK
  - Degenerative disc disease
  - Hip pain
- Cancers
  - cervical, uterine, rectal, or bladder

Endometriosis

- Analgesia: paracetamol and NSAID
- Offer hormonal treatment, eg: COCP, POP, depot contraception, IUS
- Refer gynaecology
  - Imaging (doesn't rule out)
  - Ca125 (doesn't rule out but may be raised)
  - Diagnostic laparscopy +/- ablation of endometriomas
  - GnRH analogues

Anaemia in Pregnancy

Anaemia in Pregnancy

- Physiological requirements for iron in pregnancy are three times higher than in non-pregnant menstruating women and iron requirement increases as pregnancy advances.
- Haemodilution will result in Hb drops during pregnancy and subsequent reduction in oxygen-carrying capacity.
- Anaemia is defined as:
  - an Hb level <110 g/L at booking;
  - Hb level of <105 g/L, in the second and third trimesters
  - 100 g/L postpartum
- Iron deficiency anaemia is characterised by low MCV
- Normal MCV (76-96 fl) with low Hb is typical of pregnancy.

Anaemia in Pregnancy

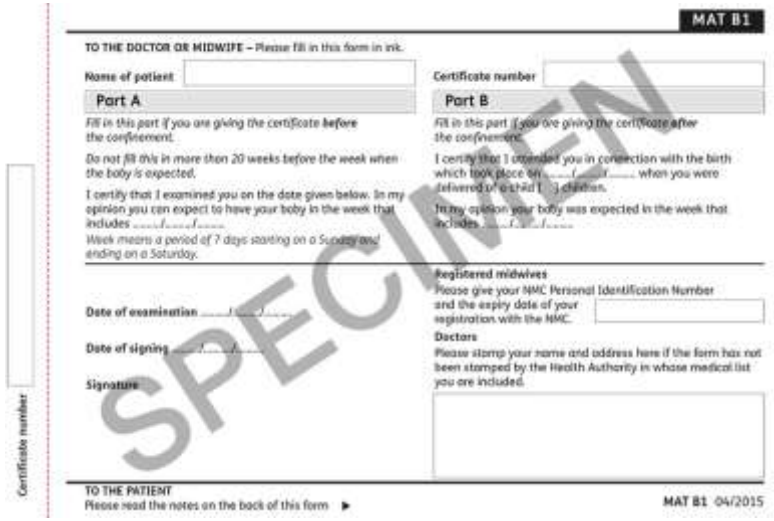
- Normal MCV (76-96 fl) with low Hb is typical of pregnancy.
- If MCV≤76 fl then the probable cause is iron deficiency but, if markedly lower than the degree of anaemia as well has having a raised red blood cell count, this suggests possible B_2-thalassaemia
  - Women with thalassaemia should have specialist antenatal care, high-dose folate (5mg OD), frequent ultrasound scans, regular Hb monitoring and transfusions.
- Others to consider: Sickle cell anaemia, anaemia of chronic disease, Lead poisoning (old paint)

Anaemia in pregnancy

- Routine iron replacement in pregnancy is not recommended in the UK.
- Women with known haemoglobinopathy should have serum ferritin checked and be offered oral supplements if their ferritin level is low (<30 µg/L).
- Women not known to have a previous problem who have a normocytic or microcytic anaemia, should start a trial of oral iron and haemoglobinopathy screening should be offered.
- Non-anaemic women at increased risk of iron deficiency should have a serum ferritin checked early in pregnancy and be offered oral supplements if ferritin is low.
- Once women become iron-deficient in pregnancy it is not possible to ensure repletion through diet alone and oral supplementation is needed.
    - E.g. as ferrous sulfate 200 mg daily, checking Hb at 2-3 weeks to ensure an adequate response

MAT B1

- The Maternity Certificate (MAT B1) enables a pregnant woman to claim:
  - Statutory Maternity Pay (SMP) from her employer
  - Maternity Allowance (MA) from Jobcentre Plus
  - Sure Start Maternity Grant (SSMG) from Jobcentre Plus
- The certificate:
  - verifies the pregnancy
  - confirms the date of the expected week of confinement (EWC)
  - confirms the actual date of birth when completed after confinement
- Doctors or registered midwives must issue form MAT B1 free of charge to their pregnant patients for whom they provide clinical care.
- It's important that MAT B1s are issued:
  - only when you are satisfied your patient is pregnant
  - not more than 20 weeks before the EWC


MAT B1

TO THE DOCTOR OR MIDWIFE – Please fill in this form in ink.

Name of patient

Certificate number

Part A

Fill in this part if you are giving the certificate before the confinement.

Do not fill this in more than 20 weeks before the week when the baby is expected.

I certify that I examined you on the date given below. In my opinion you can expect to have your baby in the week that includes ..../..../....

Week means a period of 7 days starting on a Sunday and ending on a Saturday.

Part B

Fill in this part if you are giving the certificate after the confinement.

I certify that I attended you in connection with the birth which took place on ..../..../.... when you were delivered of a child / children.

In my opinion your baby was expected in the week that includes ..../..../....

Date of examination ..../..../....

Date of signing ..../..../....

Signature

Registered midwives

Please give your NMC Personal Identification Number and the expiry date of your registration with the NMC.

Doctors

Please stamp your name and address here if the form has not been stamped by the Health Authority in whose medical list you are included.

SPECIMEN

Certificate number

TO THE PATIENT

Please read the notes on the back of this form ▶

MAT B1 04/2015

Depression in Pregnancy

Depression in pregnancy

- Untreated antenatal depression is associated with poorer pregnancy outcomes, adverse child development outcomes, and postnatal depression
- Women with antenatal depression who require psychological therapy should be fast-tracked for psychological assessment and treatment
- Discuss the option of antidepressants with women experiencing moderate to severe antenatal depression—the risks of untreated illness often outweigh the risks of antidepressant use in pregnancy in most cases

Depression in pregnancy

USE OF SERTRALINE IN PREGNANCY

Date of issue: June 2022, Version: 3

bumps A corresponding patient information leaflet on **USE OF SERTRALINE IN PREGNANCY** is available.

Sertraline is a selective serotonin reuptake inhibitor (SSRI) used in the treatment of depression, obsessive-compulsive disorder, post-traumatic stress disorder, social anxiety disorder and panic disorder with or without agoraphobia.

The available data regarding gestational use of sertraline are conflicting, with the majority of studies demonstrating no statistically significant increase in the overall risk of any malformation or of cardiovascular malformations following first trimester exposure. It is therefore unclear whether the available findings concerning maternal sertraline use in pregnancy represent a risk with the individual drug, a class effect of SSRIs, or are produced due to confounding from other factors related to the maternal illness. Those studies which have indicated increased risks have generally suggested that the absolute risks remain low (~1.4 times the background risk).

Studies which have investigated the risk of miscarriage, intrauterine death, preterm delivery, low birth weight and neurodevelopmental delay following sertraline use in pregnancy are reassuring overall but are generally too limited to fully rule out increased risks.

In utero exposure to SSRIs in the weeks prior to delivery confers a risk of transient neonatal withdrawal syndrome and infants should be delivered in hospital and monitored for associated central nervous system, motor, respiratory and gastrointestinal symptoms.

An increased risk of persistent pulmonary hypertension of the newborn (PPHN) has been reported following exposure to SSRIs as a class beyond 20 weeks of gestation. The current estimate of the absolute risk of PPHN following SSRI exposure is <0.4% (background rate 0.1 to 0.2%), suggesting that it remains uncommon following exposure. However, as PPHN is potentially serious, this should be discussed with women considering SSRI use in pregnancy.

The Medicines and Healthcare products Regulatory Agency (MHRA) has advised that there is, overall, a small overall increased risk of postpartum haemorrhage (PPH) attributable to SSRI/SNRI use in the month prior to delivery, but this risk may be higher in women with other risk factors for abnormal bleeding. Studies have identified up to a 1.3-fold increased risk following gestational use of an SSRI; should this prove

ukTIS
uk teratology information service

https://uktis.org/

Perinatal Mental Health Team

NHS
Greater Manchester Mental Health
NHS Foundation Trust

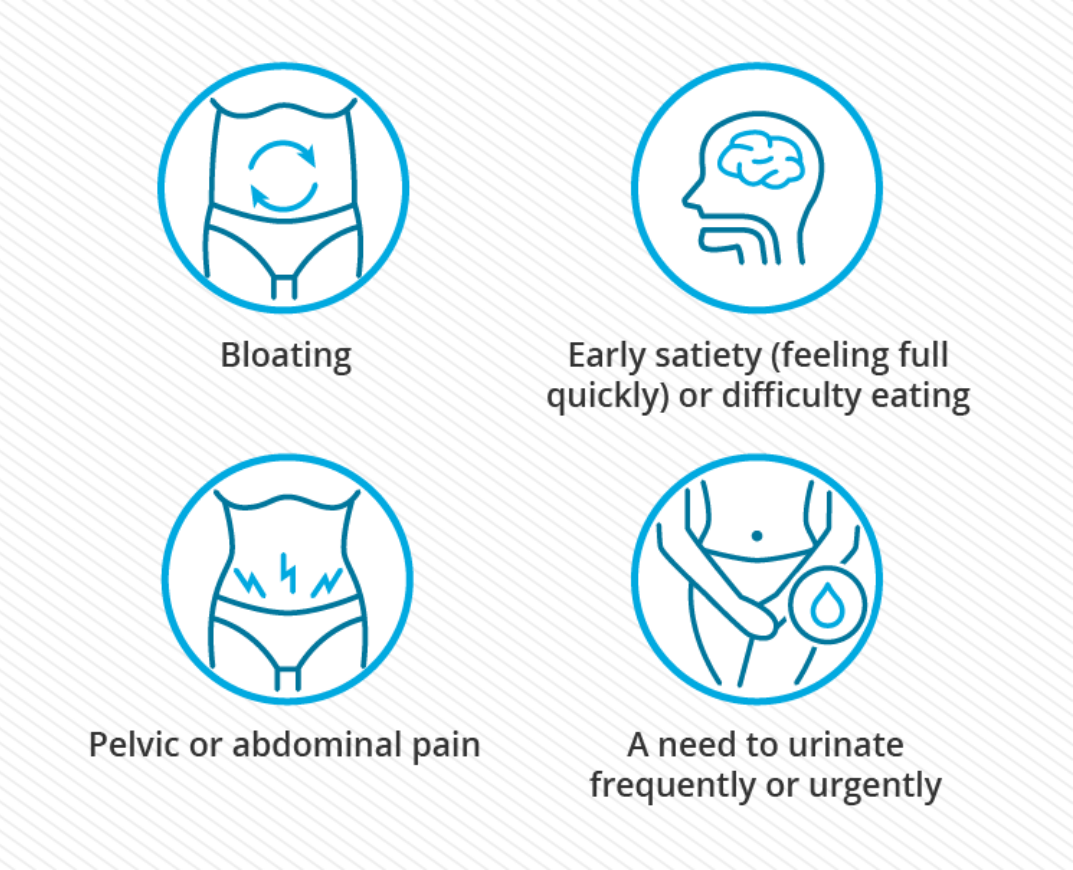
https://youtu.be/m9OSN9APkUQ?si=4LzZXz5-Ab1iAlGW

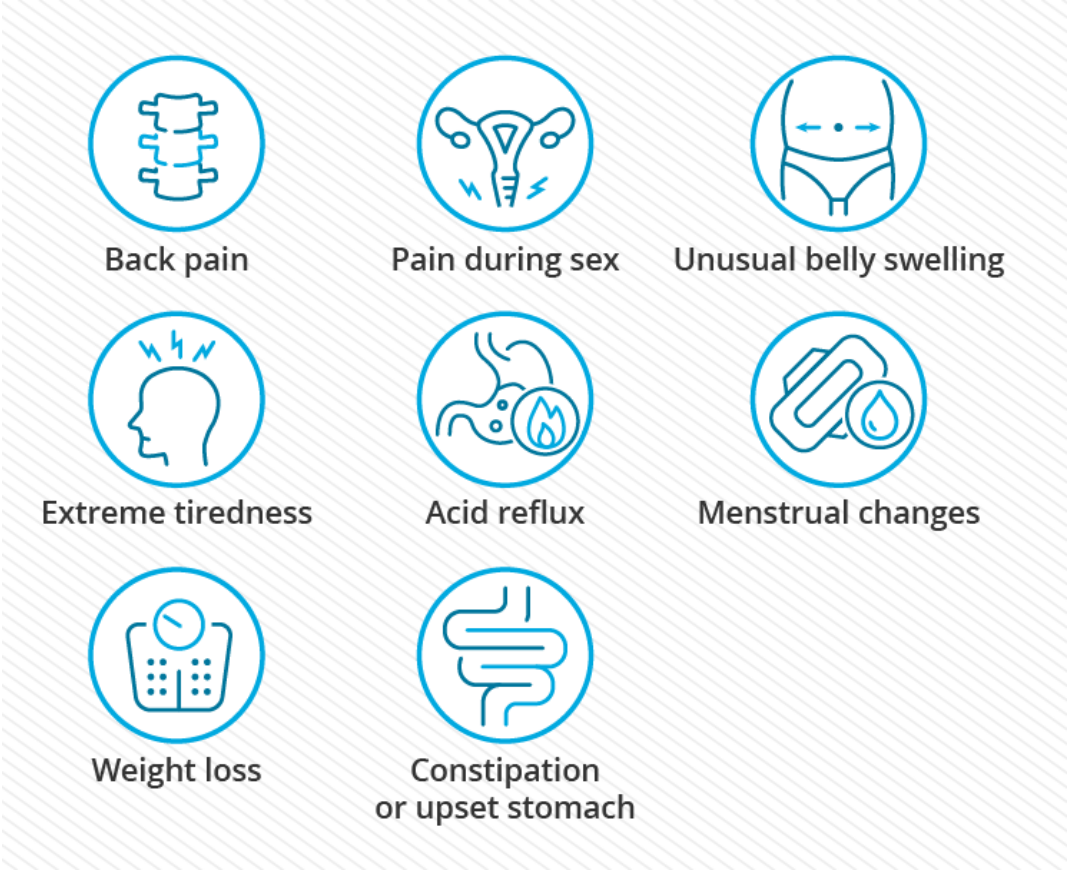
The Specialist Perinatal CMHT is commissioned to support women who experience high-risk mental health problems during and after pregnancy, and for their infant up to the age of one year.

Mental health support just before and after giving birth
Specialist Perinatal Community Mental Health Team

Ovarian Cancer

Ovarian Cancer





Ovarian Cancer

- **Carry out an abdominal and pelvic examination.**
  - Look for ascites, or a pelvic or abdominal mass (which is not caused by known uterine fibroids)
- **If the examination is normal, measure serum CA125 concentration.**
  - **If >35 IU/mL or greater), arrange an urgent ultrasound scan of the abdomen and pelvis.**
  - **If <35 IU/mL), or if raised but with a normal ultrasound:**
    - Consider other causes for symptoms or a raised CA125.
    - If no other clinical cause is apparent, advise the woman to return for review if her symptoms become more frequent and/or persistent.

- In one study, CA125 had a sensitivity of 77% for all ovarian cancers and 85% for invasive subtypes (those responsible for most ovarian cancer mortality).
  - A significant proportion of women have levels below the recommended cut-off

	Ovarian		
Women	***n***	**PPV**	**(95% CI)**
Abdominal bloating/distension	395	0.54	(0.48, 0.59)
Abdominal pain	1,043	0.19	(0.17, 0.20)
Change in bowel habit	100	0.16	(0.13, 0.19)
Dyspepsia	358	0.12	(0.11, 0.13)
Dysphagia	20	0.04	(0.02, 0.06)
Rectal bleeding	73	0.06	(0.05, 0.08)

Positive Predicted Value

	Disease present	Disease absent
Positive test	True positive	False positive
Negative test	False negative	True negative

$$PPV = \frac{\text{True positive}}{\text{True positive + false positive}}$$

- The sensitivity of a test is the proportion of people who test positive among all those who actually have the disease.
- The specificity of a test is the proportion of people who test negative among all those who actually do not have that disease.
- The positive predictive value is the probability that following a positive test result, that individual will truly have that specific disease.

Vulvovaginal Atrophy

Vulvovaginal Atrophy/Atrophic Vaginitis

- During the reproductive years, the vaginal epithelium thickens under the influence of oestrogen & produces glycogen. As they die, the glycogen-rich cells provide food for *Döderlein's bacilli*, which in turn produce lactic acid, maintaining an acidic vaginal environment. After the menopause, oestrogen levels fall and this produces changes in the vagina:
  - Vaginal mucosa becomes thinner, drier, less elastic and more fragile & can inflame.
    - Inflammation can then contribute to urinary symptoms.
  - Changes in vaginal pH and vaginal flora may predispose to urinary tract infection or vaginal infections.
  - Reduced oestrogen levels may affect periurethral tissues and contribute to pelvic laxity and stress incontinence.

Vulvovaginal Atrophy/Atrophic Vaginitis

Symptoms

- There may be no symptoms.
- Dryness of the vagina
  - most common symptom, affecting ≈93%
- Burning/itching of the vagina or vulva.
- Dyspareunia.
- Vaginal discharge (usually white or yellow).
- Vaginal bleeding or postcoital bleeding.
- Urinary symptoms
  - e.g., increased frequency, nocturia, dysuria, recurrent UTI, stress incontinence or urgency.
- Decreased arousal, desire and orgasm

Signs

- External genitalia may show reduced pubic hair, reduced turgor or elasticity, and a narrow introitus.
  - Be aware that vaginal examination may be uncomfortable or painful if the patient has atrophic vaginitis.
- Vaginal examination may show:
  - Thin mucosa with diffuse erythema.
  - Occasional petechiae or ecchymoses.
  - Dryness.
  - Lack of vaginal folds.
  - Prolapse of urethra and/or vagina.

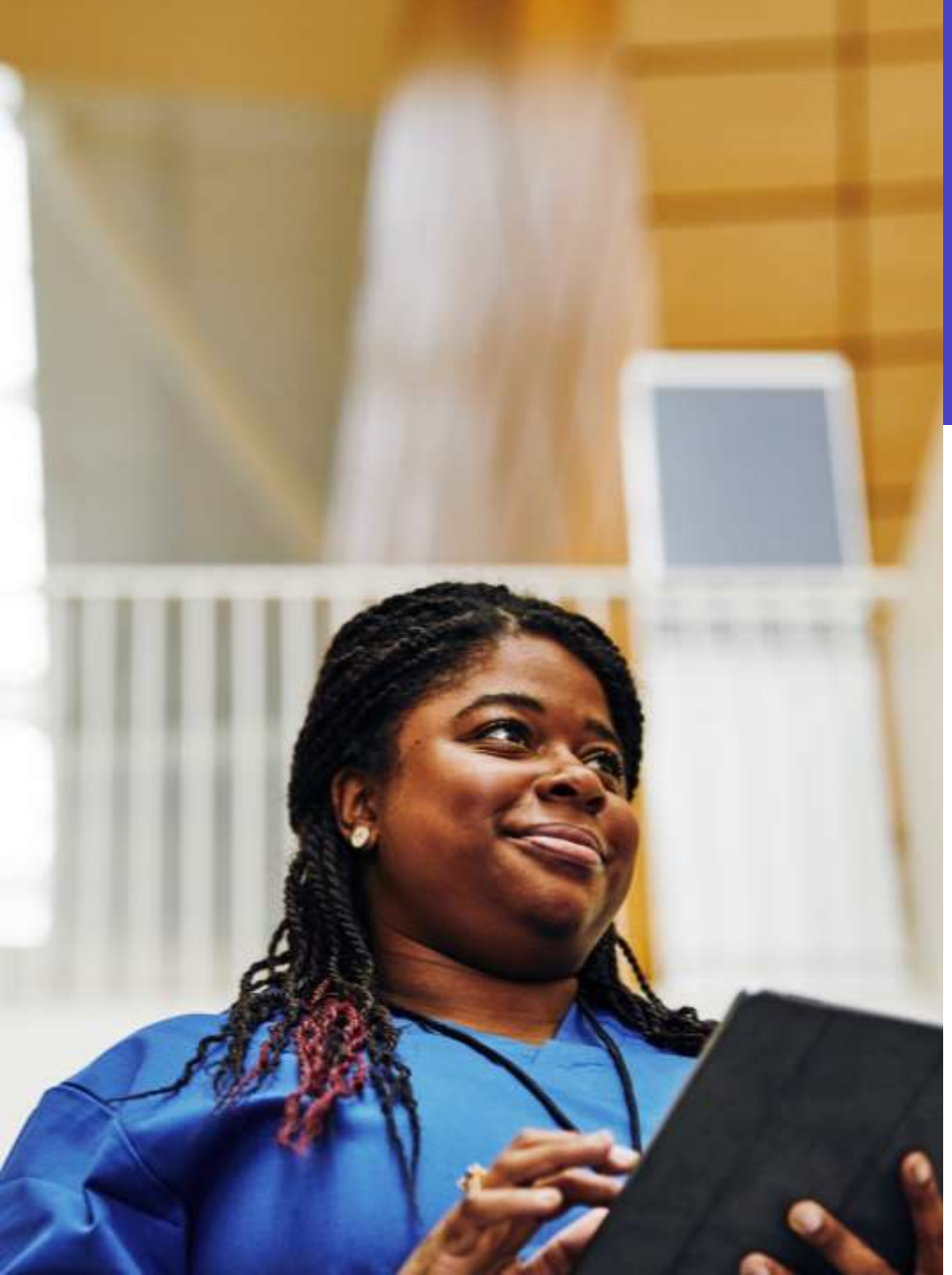
Vulvovaginal Atrophy/Atrophic Vaginitis

- Lubricants: Sylk, Astroglide, Replens, Yes
- Moisturiser: Replens MD, Regelle, Yes VM
- Topical Oestrogen: estriol/estradiol
- HRT

PRODUCT	DRUG	FORMULATION	OESTROGEN DOSE PER APPLICATION	APPLICATIONS PER PACK
Ovestin	Estriol	Cream	500mcg	30
Blissel	Estriol	Gel	50mcg	30
Imvoggis	Estriol	Pessary	30mcg	24
Vagifem	Estradiol	Pessary	10mcg	24
Vagirux	Estradiol	Pessary	10mcg	24
Gina	Estradiol	Pessary	10mcg	24
Estring	Estradiol	Silicone Ring	7.5mcg per 24hrs	1

- *prasterone [Intarosa] pessary*
  - *studies show improvement compared to placebo only*
- *ospemifene [Senshio] oral tablet*
  - *no clear evidence benefit over topical preparations*

Breast Lumps



Breast Lumps

- “Every breast lump should be referred to secondary care”
  - Discuss

“Every lump should be referred to secondary care”

For

- No cancers missed
- Provides reassurance

Against

- Overdiagnosis/overtreatment of benign disease
- Anxiety
- Resource implications

Age-based approach to a palpable breast lump

Age	Common causes	Tests	Red flags
≤ 19	Fibroadenoma cysts Hamartoma Fat necrosis Abscess	Clinical examination	Irregular firm mass Skin erythema or tethering Spontaneous bloody nipple discharge New onset nipple retraction Rapidly enlarging mass
≥ 20 to ≤ 24	Fibroadenoma Inflammatory breast conditions cysts Hamartomas	Clinical examination Ultrasound	
≥ 25	Fibroadenomas Inflammatory breast conditions cysts Breast cancer	Clinical examination Ultrasound Include mammogram if older than 40 years Core needle biopsy	

Fibroadenoma

- Fibroadenomas are benign fibroepithelial breast lesions
  - More common in pre-menopausal women
- As many as 10% of women may have fibroadenomas
  - of them, 10-15% may have multiple fibroadenomas (in either breast)
- The natural history suggests that about 50% of fibroadenomas will resolve spontaneously, 25% will not change and 25% will get bigger
- Very few fibroadenomas presenting as a palpable lump (0.58%) are likely to have atypia, in-situ or invasive malignancy within or adjacent to the lesion
- Even if a fibroadenoma increases in size it is very unlikely to contain a malignancy in the epithelial component or be an undiagnosed phyllodes tumour (2.4%).Fibroadenomas that increase in size may warrant re-biopsy and should not automatically be surgically excise.d

New pregnancy

New Pregnancy

- Routine antenatal care includes:
  - 10 antenatal appointments for nulliparous women
  - 7 antenatal appointments for parous women.
  - 2 ultrasound scans
    - a ‘dating scan’ (between 11+2 weeks and 14+1 weeks)
    - a ‘fetal anomaly scan’ (between 18+0 weeks and 20+6 weeks).
- Women with uncomplicated pregnancies are usually managed in the community by a midwife.
  - GPs, obstetricians, and specialist teams become involved when additional care is needed.

- Advice at first contact:
  - folic acid and vitamin D
  - lifestyle factors that may affect the pregnancy
- Advice on staying healthy during pregnancy should be provided,
  - Immunization for flu, whooping cough, COVID-19.
  - Infections that can impact on the (such as GBS).
  - Reducing the risk of infections.
  - Safe use of medicines and health supplements.
  - Mental health.
  - Lifestyle factors
  - Sleep position after 28 weeks of pregnancy.
  - Travel including air travel (from 28-36 weeks)
  - Occupation

Gender bias

Knowledge gaps

- A lack of inclusivity in medical research has led to gaps in knowledge.

Lack of women in leadership

- The pervasive view that “Men are better leaders” can discourage and disbar women form leading

Delayed diagnoses

- A 2019 analysis in Denmark, for example, found that in 72% of cases, women waited longer on average for a diagnosis than men.

Inadequate symptom management:

- For example, doctors who dismiss the severity of chronic pain may not provide women with pain medication.

Avoidance of medical care:

- People who no longer trust medical professionals or organizations due to negative experiences may avoid getting necessary care. This may be a factor in vaccine hesitancy. A Harvard survey found that only 47% of nonpregnant women who did not trust public health agencies planned to get the COVID-19 vaccine.

Abuse, neglect, and death:

- Gender bias can lead to actions that increase the risk of patients dying. For example, the idea that heart attacks mainly occur in males

Summary of Cases

- Perinatal mental health
- Miscarriage
- Menorrhagia
- Endometriosis
- Vulvovaginal atrophy
- Preconception Advice
- Normal pregnancy
- Contraception (over 40)
- Ovarian cancer
- Use of interpreters
- MATB1