Ruth Adewuya, MD (host):

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Ruth Adewuya, MD (host):

This episode is part one of a new mini series called The Pediatric Pulse, presented in collaboration with Lucile Packard Children's Hospital. I'm joined today by Dr. Nichole Tyson and Dr. Paula Hillard to discuss pediatric and adolescent gynecology.

Ruth Adewuya, MD (host):

Dr. Nichole Tyson has practiced gynecology and pediatric and adolescent gynecology for 21 years, and is passionate about helping and empowering younger patients. Dr. Tyson founded the Kaiser Sacramento region's OB-GYN Teen clinic in 1999, as a chief resident at UC Davis. She joined Stanford in late 2020 as a Clinical Associate Professor of Obstetrics and Gynecology, and was appointed as the Stanford OB-GYN Assistant Program Director for the residency.

Ruth Adewuya, MD (host):

Dr. Paula Hillard is a Professor of Obstetrics and Gynecology at Stanford University. She, currently, directs the program in pediatric and adolescent gynecology at the Lucile Packard Stanford Children's Hospital. She is a past president of the North American Society for Pediatric and Adolescent Gynecology, and the editor-in-chief of the Journal of Pediatric and Adolescent Gynecology.

Ruth Adewuya, MD (host):

I am very pleased to be chatting with both of you on this topic. As you are very aware, the adolescent patient may present a challenge for the practitioner, as they may be hesitant to provide personal information, or be anxious regarding the physical exam. Thank you both for joining me today.

Dr. Paula Hillard (guest speaker):

My pleasure.

Dr. Nichole Tyson (guest speaker):

It's great to be here. Thanks for having us.

Ruth Adewuya, MD (host):

So, let's start our conversation with defining pediatric and adolescent gynecology.

Ruth Adewuya, MD (host):

Dr. Hillard, can you tell our listeners what is pediatric and adolescent gynecology?

Dr. Paula Hillard (guest speaker):

So, it's a question that I actually get asked a lot. People aren't very familiar with pediatric and adolescent gynecology. Sometimes they think about adolescent OB and pregnant teens. And one of the things that I sometimes say is that part of what we do is preventive obstetrics. So, there are many reasons that

adolescence is not necessarily the healthiest time for an individual to be pregnant. And so, contraception is a part of what we do, but we take care of the gynecologic needs of everything from newborns, all the way up through adolescents and even young adults. So, we sometimes say that we practice adolescent and young adult gynecology, AYA. So, gynecologic needs of pre-pubertal girls vulvovaginal conditions are very common, but pre-pubertal young girls get ovarian cysts, and have developmental variants, and abnormalities as well.

Dr. Paula Hillard (guest speaker):

And adolescents get many of the same things gynecologically that adults do, but there are some additional conditions that are likely to present much more commonly during adolescence. For example, the developmental abnormalities of the genital tract that can sometimes include obstructive variants, where there is a blockage to menstrual outflow. And that's also one of the things we deal with. We do complex contraception for girls with complex medical problems, and see girls for other complicated gynecologic problems.

Dr. Nichole Tyson (guest speaker):

I think that's a great description of many of the things that we do. Some of the conditions that Dr Hillard was alluding to are, often, quite complicated. Sometimes their anatomy like their Mullerian development and endocrine needs. And certainly here, at Stanford, a lot of the complex medical problems, but I think it's something that we're really equipped and skilled at caring for. And it can sometimes be a little bit more complicated than in a general gynecology practice.

Ruth Adewuya, MD (host):

Thanks for that.

Ruth Adewuya, MD (host):

And so, Dr. Tyson compared to general gynecology, how does pediatric and adolescent gynecology meet the unique needs of girls and young women?

Dr. Nichole Tyson (guest speaker):

We are really comfortable working with this population. I think one of the things that's always a joy for us who do PAD, pediatric and adolescent gynecology is we love what we do. So, we love taking care of the child, the younger patient. And we also love these adolescents. They're our joy.

Dr. Nichole Tyson (guest speaker):

When you think about where we get our referrals and our consultations, they come from largely the adult gynecologists, who don't necessarily have a lot of familiarity, or comfort taking care of the pediatric patient, for sure. And many of them, same thing goes for adolescents. And, certainly, our pediatric colleagues do often struggle taking care of the adolescent population, but that's our bread and butter.

Dr. Paula Hillard (guest speaker):

So, in addition to the things that Dr. Tyson has described, one of the other things that's different about adolescent gynecology is adolescent development. An 11 year old is not the same as a 14 year old, or a 16 year old, or an 18 year old in terms of these developmental tasks. So, adolescents are developing

physically. They are developing cognitively, going from being very concrete in their thinking to being able to think abstractly. They're developing socially with relationship to their peers and their families. And all of these developmental tasks are taking place at the same time, but not always at the same pace. And these are not things that the typical general gynecologist is thinking about in relationship to adults. But we have to consider all of those things in relationship to adolescents.

Ruth Adewuya, MD (host):

What are some specific scenarios that come to mind in which a patient should be referred to a pediatric adolescent gynecologist?

Dr. Nichole Tyson (guest speaker):

I, certainly, can jump on that one easily, because as Dr. Hillard was talking, I was thinking about one of the other added benefits to seeing a pediatric and adolescent gynecologist is how we are in more tune with irregular menstrual cycles, either heavy ones, or painful ones. And we know conditions like endometriosis can entail a 10 year delay of diagnosis. Whereas, we intervene a lot earlier, and can recognize these problems, and save girls a lot of discomfort, and misery, and missed school and, perhaps, enhancing their future fertility by intervening earlier. Menstrual problems would be, in a nutshell, a great option to see us sooner than later.

Dr. Paula Hillard (guest speaker):

So, in the pre-pubertal age group, there are girls with vulvovaginal conditions that don't respond to simple measures of hygiene, and seeing us is certainly something that we are happy to do. So, vulvovaginal conditions and young girls are often referred to us for challenges.

Dr. Paula Hillard (guest speaker):

And then, of course as we've alluded to previously, the complex anatomical issues that are really quite rare are things that we see commonly because we get the referrals, and the community primary doctor, or pediatrician, or OB/GYN, probably hasn't seen these things. Conditions such as uterovaginal agenesis, Mayer-Rokitansky-Kuster-Hauser syndrome, MRKH, we see quite regularly. So, we are used to dealing with those challenges.

Dr. Paula Hillard (guest speaker):

We also get referred from primary doctors, girls with ovarian cysts that are persistent and that's another area. Once a little girl is out of diapers, and prior to reaching puberty, when she's developing breasts and producing estrogen, and the skin of the vulva and vagina is changing, little girls generally don't get yeast infections. And I see so many girls who have been treated by adult gynecologists, or their pediatricians for a vulvovaginal yeast infection because the child is having some itching. And that is almost never seen. It is extremely rare to see a yeast infection in a child of that age. So, that's certainly one thing that is very different about pediatric gynecology, and that many clinicians are not so aware of.

Dr. Nichole Tyson (guest speaker):

The other part, that's trending that I probably see a consult a week now, maybe more actually, is this sort of abnormality, or perception of vulvar anatomy abnormality, labial hypertrophy the infamous, "What is wrong with my child's labia? It looks different than mine. It's asymmetric. Does she need surgery?" A lot of it is empowering and educating, and reassuring, and referring to great reputable

resources of what looks normal, so that the families can feel reassured, and the child can feel confident and happy.

Ruth Adewuya, MD (host):

The American College of Obstetrics and Gynecology recommend that girls have their first reproductive health visit between ages 13 and 15. Do you find that most patients have a preventative health visit according to this guideline? Or do you typically see patients once an issue arises?

Dr. Paula Hillard (guest speaker):

I don't think that recommendation is as widely known as I would like it to be. And I don't think that it's happening as often as I would like it to be happening. And partly because mothers sometimes misunderstand, if they have heard it, they misunderstand what we're saying. We're not saying that a 13 year old needs an exam as a 25 year old would need. She doesn't need a speculum exam, or a Pap smear, or an internal gynecologic exam. She needs a visit to talk about adolescent growth and development. To talk about her periods to answer any questions that she needs answering confidentially, because part of what needs to be provided for the gynecologic care of adolescents is assurances of confidentiality within the limits of the law.

Dr. Paula Hillard (guest speaker):

So, there are legal limits that if we are worried about out a patient's self harm or other harm coming to this patient, then that is something we must disclose. But, other than that, assurances of confidentiality are really important to this age group. When given those assurances, not only will kids disclose to us things that are concerning to them, and big concerns like gender identity, or like a history of sexual assault, or even voluntary sexual activity is regularly disclosed to us when it hasn't been disclosed to others. When the adolescent is given those assurances of confidentiality, kids will ask other questions that are seemingly pretty innocuous, but are troubling them. "Is it normal for my breasts to be different sizes? Is it okay that I've got hair in this location or that?" And those kinds of concerns that weigh on adolescent's mind and psyche are questions that we get regularly when we provide those assurances of confidentiality.

Dr. Paula Hillard (guest speaker):

We were concerned when we wrote this statement, initially, that we would be stepping on the toes of pediatricians, and family doctors, who can provide preventive guidance, and these kinds of visits. I struggled for a while in my practice to figure out how I could determine if a young woman who was already seeing a clinician needed to see me? And what I eventually came down to is the question of the mom. And so, often, these were my adult patients who were saying, "My daughter is now 13, should she see you?" And the question that I would ask the mom in response is, "When your daughter sees her primary doctor, does she have an opportunity to talk with that clinician privately and confidentially?"

Dr. Paula Hillard (guest speaker):

And if the answer is no, then I would say that clinician isn't taking the time, or doesn't feel comfortable answering those confidential questions that teens have. So, if that's the case, then I need to see that teen. If that team is talking with their clinician privately, I may still need to see her, if she's having problems, but I don't necessarily need to be the one to do that first reproductive health visit.

Ruth Adewuya, MD (host):

In line with what you just said, your population may sometimes have some anxiety about having those conversations with clinicians. Dr. Tyson, what are some techniques that clinicians should utilize for initial evaluation, or having that first conversation with your patient?

Dr. Nichole Tyson (guest speaker):

We get that question and inquiry from our residents, and our fellows, and our medical students, and even our pediatric colleagues. I think that every young woman should meet a gynecologist at this young age. This is an opportunity to have her, or him, or them speak for themselves and start to communicate with their own doctor, because they're going to spend most of their lives doing that. In a world where we have such a difficulty with medical literacy, and empowering our young women this is a great chance to meet their doctor and represent themselves and learn to advocate for their own health and wellbeing. Or if they have a problem, or a concern. So, I think having that first confidential visit with their doctor is just so critical.

Dr. Nichole Tyson (guest speaker):

It is challenging to distract the child from the parent and letting the diad trust us, if you will. There's no time like the present to learn. It doesn't have to be done that first visit. We want to introduce that. So, now, the next time you come to see me for follow up, we're going to meet alone and have a talk. And I would say 75, 80% of the time, patients and parents are very receptive, but there are those ones who even the patient is just like, "No, I don't want to, I'm nervous." They don't want to go against kind of the family and cause anything upsetting. But I think when you frame it of, "This is what we do routinely. Not that I see something worrisome with your child or you," you start to start off with the safe topics. "Who's at home? Where you're going to school? What kind of activities do you like?" And then, you dive into the more sensitive things, "Have you or friends ever explored having sex, or doing drugs, or tried vaping?" Being sensitive to where they are.

Dr. Nichole Tyson (guest speaker):

And it, certainly, depends on their age, and their developmental capacity because I think even patient who struggle, perhaps, with communication or developmental delay still deserve and warrant this time with us. And so, you really have to tailor those conversations. And I often preface it with, "These are confidential conversations, that I'm not trying to be nosy and retrieve information. I want to know what you're doing. And so, I can keep you safe and give you the best recommendations. And you can feel comfortable talking about that. Recognizing that you're a teenager, and teenagers explore, and take risks and try new things. So, let's talk about it."

Ruth Adewuya, MD (host):

You both talked about some of the more common pediatric and adolescent gynecological issues that you saw. I wanted to dive into a little bit more detail with one from each of you about your approach to your care. And some of the challenges that you see.

Dr. Paula Hillard (guest speaker):

Probably the most common one that I see and have seen over the years is period problems. That encompasses a lot. She hasn't had her period, and at an age when we would expect her to, and that's one of the issues where the textbooks are not quite so evidence based. Many of the textbooks say that you wouldn't evaluate no periods until the young woman is 16. And all of the evidence, virtually all of the evidence says that 15 is an age that we should be concerned, if not earlier. Earlier, if she's had has

signs of hormone imbalance, androgen excess, or polycystic ovary syndrome, or has signs of an eating disorder, for example, or over exercising. Those would all be things to explore related to no periods.

Dr. Paula Hillard (guest speaker):

But no periods is one thing, but too much bleeding is also way, way common. There's this idea out there that within the first two gynecologic years, that is the first two years after a young woman has her first period, or menarche that cycles are irregular, and it's sort of anything goes. And that is clearly not what the evidence shows us. The evidence shows us that even though early cycles are not consistently ovulatory, there are some parameters that are statistically based.

Dr. Paula Hillard (guest speaker):

So, statistically, most young women in those first two years have periods that are cycles that are from 21 to about 45 days apart. So here, it implies that we've got some data to be able to look at this. And I can't tell you how many kids have come to me with the problem being stated as irregular periods. And they can't reconstruct what their periods were like over the last year.

Dr. Paula Hillard (guest speaker):

One message that I would give to primary clinicians is please, please, please ask your patients to track their cycles. They can learn about their cycles in that way. And if there are problems related to periods coming too often, or too heavy, or lasting too long, we have some data. I recommend that they track it, however, they're actually going to do it. Whether it's writing down the dates on a piece of paper, or charting on their favorite cat calendar that they bring in to show me, or many girls now are using apps. Whatever form they can bring it in, bring it to me. I will transcribe it, and put it in a form that I can understand, but just do it is really the main thing that I would say.

Ruth Adewuya, MD (host):

Dr. Tyson, how about you? What is one common pediatric and adolescent gynecologic issue that you see, and what's your approach to care?

Dr. Nichole Tyson (guest speaker):

I will see a myriad of patients for period problems. You can't see me, but I'm air quoting, when they're actually coming for other issues. They want to talk to their doctor. Is it about they're having sex and they want birth control, but they're presenting with a period problem, because that's safe? A lot of times we don't necessarily recognize that an entry to a doctor can come with all sorts of different complaints. Things that we often address through these different chief complaints are things like sexual orientation and gender identity. And they present with a period problem, which is, "I don't want my periods anymore because they make me unhappy and miserable with myself." Or, "I have been traumatized by someone in the past and I need help." So, really trauma informed care has been a really big part of our practice.

Dr. Nichole Tyson (guest speaker):

Thinking about consent and promoting sexuality and healthy relationships. I think with COVID one of the beauties that have come out of the silver lining of this virus and vaccine time is talking about the HPV vaccine, and we're capturing a large chunk of patients who didn't get it when they were 9, 10, 11, 12, and now we're seeing them, and having the opportunity to have more robust HPV vaccine discussions, if

you will. And I think, we routinely survey, and talk about things like vaping, and e-cigarettes, and eating disorders. And I talk to patients about sunscreen, or what does this tattoo, and all these piercings. And so, really talking about hot topics that are occurring in our teens today that are beyond sort of the scope of kind of routine pediatric, or gynecologic care, if you will.

Dr. Nichole Tyson (guest speaker):

Not to go off the topic, but I think that's how pediatric and adolescent gynecology is. You start on one topic and you actually dive in a little further, and found there's this whole other layer, or two, or three that you can identify.

Ruth Adewuya, MD (host):

That's excellent. A little bit of a microcosm of your office visit where it's one thing, and then you go into several other directions.

Ruth Adewuya, MD (host):

Earlier in our conversation, you both alluded to hygiene. So, let's talk about hygiene. Why is gynecological hygiene important, and how do you recommend girls practice hygiene?

Dr. Paula Hillard (guest speaker):

In thinking about one message to clinicians who take care of little girls that's hygiene, hygiene, hygiene, sometimes primary doctors have the idea that a girl taking a bath is a problem. And no, it's generally not a problem. Bubble baths can be because the chemicals, and the soaps in the bubble baths can be irritating to the bubble vulvovaginal area. But a child standing in the shower doesn't really always get the labia, and the genital area as clean as it needs to be. So, a focus on hygiene is something that general primary docs can emphasize.

Dr. Paula Hillard (guest speaker):

There have been some recent marketing efforts of products marketed toward teenage girls to convince them that their vaginas were unhealthy, and needed a certain product to keep them clean and fresh. It's just a really insidious sort of thing. Vaginas are pretty remarkable parts of the body that balance out the bacteria, and keep themselves healthy the vast majority of the time. And if there's a problem, then you need to think about what's really causing it rather than trying to it up with a vaginal product of some sort, a douche, or a vaginal feminine hygiene product.

Dr. Paula Hillard (guest speaker):

I generally am a fan of baths, even for adolescents. We talked about it with pre-pubertal girls, but adolescent girls could probably benefit from taking a bath periodically, and soaking in the tub, and washing away the surface epithelial cells that kind of get caught, and trapped between the folds, but just plain old water is a good thing for that. And you don't need much in the way of products for hygiene.

Dr. Nichole Tyson (guest speaker):

Soaking in warm water is just a magnificent option to help hygiene. But I think, of late, we get so many referrals for the opposite where it's almost over hygiene. And there's this strange diad picture we see with moms with vulvar and vaginal conditions who think, perhaps, that the daughter has the same

condition. These little girls have very different vulvas and vaginas compared to adults, and don't necessarily have the same skin or vaginal infections, or microbiome. And so, I think there's an over treatment, perhaps, that parents will sometimes presume their child needs, or over hygiene where they're washing, and scrubbing, and using crazy things to keep their vulvas clean. Where a lot of times it's just simple, warm water.

Dr. Nichole Tyson (guest speaker):

And we see at the holidays, people are getting their lush bath bombs and then come see us with these horrible contact dermatitis and infections. Sometimes we can do more harm than we recognize too. So, I think that's a really interesting area that we've been seeing a lot of consults for.

Ruth Adewuya, MD (host):

Dr. Tyson, my next question relates to what you said earlier, where your conversations with patients runs the gamut. They present with one chief complaint, and then it opens essentially a little bit of this Pandora's box sometimes. And you get to dig into more important issues that are really the reason why they came in.

Ruth Adewuya, MD (host):

Do you agree then that PAD specialists really play a role in shaping future health practices of this population?

Dr. Nichole Tyson (guest speaker):

Oh, heck yes, 100%. And it's inspiring because all of people who work in PAD, we're this very passionate sort of enablers, and [empower-ers 00:24:28] and advocates for these young women and men, and this whole generation of young people. It's a very exciting time. I think we're much more open to talking about the hard topics, or the challenging ones, or the nuanced ones. I think that's a really great place, and space to work. And I think idea of shaping the future is understanding the present and having our eyes open to it. So, then we can better educate and provide evidence based care.

Dr. Nichole Tyson (guest speaker):

I think if you don't ask the hard questions, if you don't dive in to know what's happening, then you can't provide the most up-to-date and proper care for our patients today.

Ruth Adewuya, MD (host):

How do you balance the requirements for privacy and confidentiality, while recognizing parents' legitimate concerns for their child's health and facilitating communication?

Dr. Paula Hillard (guest speaker):

I have learned over the course of the years to structure the visit, especially with a new patient in a certain way. And not everyone does this, Dr. Tyson and I do things a little bit differently. Years ago, I, working with our psychologist in the division of adolescent medicine, came up with the structure of a visit where, initially, we meet with the patient, an adolescent, and her parent. Getting the history together initially to figure out a little bit of how the communication is going between, let's just say, mom and daughter? How do they communicate in front of me? If they are bickering over everything from the date of her last period, to what she had for breakfast this morning that's one thing. If they are respectful

of one another and indicating that there's been good communication, that's lovely to see, but we get a little snapshot of that.

Dr. Paula Hillard (guest speaker):

We also hear what they're willing to talk about in front of me. So, if the daughter says, "Mom and I have been talking about contraception, and we both have some questions that we want to talk about now," great, let's talk about them together. But I don't bring that up unless they do initially. So, mom and daughter together.

Dr. Paula Hillard (guest speaker):

And then, I talk to mom for a few minutes and I actually outline the structure of the visit. I'm going to talk to the two of you together initially. Then, I'm going to take a few minutes to talk to mom privately. And then, I'm going to take a few minutes to get to know you, the patient. And in talking to mom privately, I have specific questions that I ask about how mom is feeling. Is she in a relationship? If she has a boyfriend? Do you like her boyfriend? How do they interact? Are you concerned about sexual activity, or alcohol use, or vaping, or other things? Has she had an emotional trauma in the past?

Dr. Paula Hillard (guest speaker):

And then, the other thing that comes out in that private conversation with mom is, are there family secrets? Mom may say, "She doesn't know this, but...," And give me family history or something else that is being kept a secret in the family. And that's helpful information, but you're also forming a relationship with mom. And you're both there for the same reason. Mom is there all the time with the goals of her daughter being, and staying healthy. I'm stepping in for this particular visit, and related to this particular problem, but we both have the same goals is for the daughter to be as healthy as she can be.

Dr. Paula Hillard (guest speaker):

And so, forming that relationship with mom, explaining the policies on confidentiality that I have, and then the opportunity to talk to daughter alone, to ask all the questions. But I think that few minutes with mom alone really helps to form that relationship, helps you to understand the daughter in the context of her family. And I think helps us to take better care of daughter.

Dr. Nichole Tyson (guest speaker):

I think the approach too is to empower the daughter to start engaging in her healthcare. And so, sometimes you can find in young patients, and even the older young adults, they're just not familiar. Their mom, or dad, or parent has always spoken for them, or grandparent. And so, it's fun to give them the chance to speak, to advocate. Sometimes it doesn't go so well, and sometimes they're very excited, and you really get them talking. So, it's a great allyship.

Dr. Nichole Tyson (guest speaker):

And then, I would highlight that the thing that Paula does so well, and we really all try to do so well is build that relationship with the diad, with the child and the parent, with the hopes, knowing that the parent's the biggest influence here and trying to encourage that relationship. But there are, certainly, times where that relationship is not functional and not going to work. And so, we are sort of the

champion, and the ally for the younger patient who is there to see us, that's what we can tell the patient, "I'm your doctor."

Ruth Adewuya, MD (host):

Well, as we wrap up our conversation, I have a question for both of you. If you had one key takeaway for clinicians on this topic, pediatric and adolescent gynecology, what's the key takeaway?

Dr. Nichole Tyson (guest speaker):

I think one of the big ones is that we, I mean, I think that a lot of times people don't even know what PAD is. Dr. Hillard is the editor of our journal. There's a whole journal of pediatric and adolescent gynecology. And I think several editorials are titled What is PAD? Because people don't even know what it is that we do, that we're a subspecialty that there's fellowships, that there's conferences, that there's international organizations. We are there, and we're very good at what we do and very passionate about it. And so, I would say we are here, pediatric and adolescent gynecology.

Ruth Adewuya, MD (host):

Is here. Excellent.

Dr. Nichole Tyson (guest speaker):

Is here, to stay and growing.

Ruth Adewuya, MD (host):

Fantastic. Thank you. Dr. Hillard?

Dr. Paula Hillard (guest speaker):

I love it that Dr. Tyson gave that as the first point, that really is a biggie. And that's what we want is for people to know that we are here to help their patients, and to help girls.

Dr. Paula Hillard (guest speaker):

In terms of some messages for primary clinicians in taking care of this age group, we've mentioned hygiene, hygiene, hygiene. We've mentioned tracking of menstrual cycles. We've mentioned it's not just anything goes for menstrual cycles early on and the 21 to 45 days. I didn't mention, but would want to. Bleeding that lasts longer than 7 or 8 days is outside of that statistical range, and should not be happening. If she's been leading for the last 30 days, that's a problem. We, certainly, want to encourage responsible sexual activity at an age when a young woman can be responsible.

Dr. Paula Hillard (guest speaker):

I, certainly, gave more than one, but those would be some of the messages that I would love for listeners of the podcast to hear.

Dr. Nichole Tyson (guest speaker):

I would add a couple subtle ones too. I would say that girls shouldn't be suffering and missing school with their periods, and have to put up with it. They shouldn't have to soak through their clothes, and their bedsheets. And pubic hair is good. I would be remiss not to mention that.

Ruth Adewuya, MD (host):

Well, what better way to end this conversation, right?

Dr. Nichole Tyson (guest speaker):

It's a wrap.

Ruth Adewuya, MD (host):

Thank you. Thank you both for chatting with me today on this topic. It was great chatting with you. Learned a lot, so thank you for your time.

Dr. Paula Hillard (guest speaker):

Thank you so much.

Dr. Nichole Tyson (guest speaker):

Thank you so much, Ruth.

Ruth Adewuya, MD (host):

Thanks for tuning in.

Ruth Adewuya, MD (host):

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