Preventive Care in Women's Health

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KEYWORDS

• Women's health • Preventive care • Health maintenance • Screening tests

KEY POINTS

- Reproductive aged women often receive primary care from specialists in general obstetrics and gynecology.
- Prevention is the mainstay of health care. There are primary, secondary, and tertiary forms of prevention.
- Preventive measures may include immunizations, behavioral counseling, screening tests, and chemoprevention.
- Leading causes of death vary by age group.
- Leading causes of death can be mitigated by promoting healthy practices that focus on primary, secondary, and tertiary prevention.

INTRODUCTION

Preventive care is a major cornerstone of clinical medicine. The focus of health care is shifting from problem-based medicine toward preemptive care, seeking to intervene before harmful problems develop. Obstetric and gynecologic physicians provide approximately half of all preventive care visits in reproductive-aged women.[1] There is great opportunity to expand the focus of these visits beyond reproductive health issues. Given the wide reach of the specialty, it is important to promote disease prevention through detailed history taking, assessing risk, and coordinating the appropriate interventions in all aspects of health. Eliminating inequity and advancing health literacy among patients are also complex but important aspects of preventive medicine. This article provides an overview of preventive care, leading causes of mortality in adult women, and examples of prevention focused on these major health care issues.

Preventive care includes primary prevention, secondary prevention, and tertiary prevention. Primary prevention controls risk factors that contribute to disease with

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the goal of preventing disease onset. Secondary prevention targets early staged disease to decrease morbidity or death by eradicating or slowing disease progression. Tertiary prevention limits sequelae once a disease is fully manifested to reduce further complications. Distinctions between the three types of clinical prevention may be blurred and interventions may fulfill more than one type of prevention.

Clinical interventions supporting preventive care fall into several categories: immunizations, behavioral counseling, screening tests, and chemopreventive measures. Procedural interventions may also contribute to preventive care. Examples include bariatric surgery for obese women and prophylactic oophorectomy in patients with hereditary cancer syndromes. Deciding which interventions are appropriate for individual patients is a challenge. Evidence of overall clinical benefit as outlined by professional and scientific organizations supports decision-making.

Counseling and patient education are important components of the preventive care model. Materials supporting these efforts should be obtained from credible sources and be designed to effectively promote patient understanding.

Risk stratification is important in any preventive care program. Examples of variables contributing to risk include age, genetic, and environmental factors. Mitigation of risk is accomplished by interventions tailored to the individual's personal and hereditary attributes. For example, screening should be targeted to populations demonstrating the highest prevalence of disease to enhance cost effectiveness and test reliability. Epidemiologic data including disease prevalence and death rates help identify target groups. Leading causes of death by age in women are summarized in **Table 1**.[2] The goals of preventive interventions may evolve as patients age and risks change. In younger women, health maintenance may consist of only primary prevention including healthy habits and immunizations designed to minimize morbidity from common disorders. As women age and chronic illness becomes more frequent, care shifts to secondary prevention to include preservation of quality of life and preventing mortality. In the elderly, tertiary prevention may become the main focus.

Preventive measures should target disorders that demonstrate a burden of impairment, that have common prevalence, and that are treatable in the precursor state. Screening should be safe, accessible, and cost effective with analytical validity and clinical utility to alter the natural course of the disease. Screening tests can be evidence based, evidence informed, and based on expert opinion. Several governing bodies dictate these recommendations including US Preventive Services Task Force (USPSTF), National Institutes of Health, World Health Organization, Institute of Medicine, and Centers for Disease Control and Prevention (CDC). Other data-gathering analytical resources include the Cochrane library, and specialty-based medical societies, such as the American Congress of Obstetrics and Gynecology (ACOG) and the American College of Physicians.

Recently ACOG published the Well-Woman Task Force Report highlighting evidence that supports components of a well-woman examination with consensus from experts from 15 major organizations in women's health.[3] The task force compiled and reviewed the major recommendations of many societies and surveillance organizations, then made joint recommendations. Their completed extensive report to the US Department of Health and Human Services is based on three levels of consensus including the following categories: evidence based, evidence informed, or uniform expert agreement. Strength of the recommendation was further scored as strong or qualified. Although this document does not attempt to duplicate the recommendations of other agencies, it creates a convenient resource compiling elements of the well-woman examination. It also fills the gaps between data-driven care and practical decision making in areas with limited data. As recommendations continue to be revised,