Gynecology Past Summary

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🩺 GYNECOLOGY STUDY NOTES

📘 Topic 1: Puberty & Menstrual Physiology

🔷 Puberty Milestones (Tanner staging)

- Thelarche (breast buds): First sign
- Adrenarche (pubic/axillary hair): Shortly after
- Growth spurt: Before menarche
- Menarche: Usually ~12.5 yrs (2–3 years after thelarche)
- Trigger: GnRH pulsatility → LH/FSH ↑ → Estrogen production

🧠 Thelarche → Pubarche → Growth → Menarche

🔷 Menstrual Cycle Phases

Phase	Hormone	Endometrial change
Follicular (proliferative)	↑ Estrogen	Endometrial thickening
Ovulation	LH surge	Release of mature ovum
Luteal (secretory)	↑ Progesterone	Prepares endometrium for implantation
Menstruation	↓ Estrogen/ Progesterone	Shedding of endometrium

- Ovulation ≈ Day 14 (in 28-day cycle)
- Body temp ↑ after ovulation (progesterone effect)
- ❌ "Estrogen peaks during luteal phase" → ❌ Progesterone dominates luteal phase

📘 Topic 2: Amenorrhea

🔷 Primary Amenorrhea

- No menses by:
  - Age 13 with no secondary sexual characteristics
  - Age 15 with normal secondary sexual characteristics

Causes:

- Outflow tract: Imperforate hymen, transverse septum
- Gonadal failure: Turner (45,X), androgen insensitivity
- Hypothalamic: Kallmann syndrome (↓ GnRH, anosmia)
- Pituitary: Prolactinoma

🔷 Secondary Amenorrhea

- Absence of menses for:
  - >6 months in someone who previously menstruated
  - >3 cycles (common cutoff)

Common causes:

- Pregnancy (first to exclude)
- PCOS
- Hyperprolactinemia
- Hypothyroidism
- Asherman syndrome (intrauterine adhesions)

🔷 Workup Sequence

1. Pregnancy test
2. TSH, Prolactin

3. Progesterone challenge
    - Withdrawal bleeding = estrogen present
    - No bleed → check FSH/LH
4. Estrogen + Progesterone challenge
5. Imaging (US, MRI if needed)

❌ "Always order MRI first" → ❌ Only if suspect pituitary/hypothalamic cause

📘 Topic 3: Polycystic Ovary Syndrome (PCOS)

🔷 Diagnostic Criteria (Rotterdam – need 2/3)

1. Oligo/anovulation
2. Hyperandrogenism (clinical or biochemical)
3. Polycystic ovaries on US (≥12 follicles or >10 cm^3 volume)

🔷 Clinical Features

- Irregular periods or amenorrhea
- Hirsutism, acne, oily skin
- Obesity
- Infertility
- Acanthosis nigricans (insulin resistance)

🔷 Hormonal Pattern

- ↑ LH : FSH ratio (>2:1)
- ↑ Androgens (testosterone, DHEA-S)
- ↑ Estrogen (peripheral aromatization)
- Normal or ↓ FSH

- ❌ “FSH is increased in PCOS” → ❌ It’s usually normal or low

🔷 Ultrasound Findings

- “String of pearls” appearance
- ≥12 small follicles (2–9 mm)
- Ovarian volume >10 cm³

🔷 Management

- Lifestyle change = 1st line
- Irregular periods / Hirsutism:
  - OCPs (suppress LH/androgens)
  - Antiandrogens (e.g. spironolactone) — caution in pregnancy
- Fertility treatment:
  - 1st line: Letrozole
  - Alternatives: Clomiphene, Metformin (esp. with insulin resistance)

🧠 Letrozole > Clomiphene for ovulation induction in PCOS

📘 Topic 4: Hyperprolactinemia

🔷 Causes

- Pituitary adenoma (prolactinoma)
- Medications (e.g. antipsychotics, metoclopramide)
- Hypothyroidism
- Chest wall trauma
- Renal failure

🔷 Symptoms

- Amenorrhea, galactorrhea
- ↓ libido, infertility
- Visual field defects (macroadenoma)

🔷 Diagnosis

- Serum prolactin
- TSH (hypothyroidism can ↑ prolactin)
- MRI brain/pituitary (if prolactin persistently elevated)

🔷 Management

- Dopamine agonists: Bromocriptine, Cabergoline
- Surgery if macroadenoma + visual symptoms
- ❌ "Start with surgery in all cases" → ❌ Medical therapy is first-line

📘 Topic 5: Contraception

🔷 Combined Oral Contraceptives (COCs)

- Contain estrogen + progestin
- Inhibit ovulation (↓ FSH, LH)
- Regular cycles, ↓ menstrual flow, acne control

Contraindications (⚠️ "ACHES"):

- Active thromboembolism, stroke, MI
- Migraine with aura
- Smoker >35 years
- Breast cancer

- Liver disease

🧠 ACHES side effects = Abdominal pain, Chest pain, Headache, Eye problems, Severe leg pain

🔷 Progestin-Only Pills (Mini-Pills)

- For breastfeeding women or when estrogen is contraindicated
- Must be taken same time daily
- Primary action: cervical mucus thickening

🔷 Long-Acting Reversible Contraceptives (LARCs)

- IUD (Copper):
  - Lasts 10 years
  - Causes local inflammation → spermicidal
  - SE: heavier periods
- IUD (LNG/Progestin):
  - Lasts 3–5 years
  - ↓ bleeding and cramps
- Implants: Etonogestrel, lasts 3 years

🔷 Emergency Contraception

Method	Time window	Notes
Levonorgestrel	≤72 hrs	Less effective if BMI ↑
Ulipristal acetate	≤120 hrs	Delays ovulation
Copper IUD	≤5 days	Most effective overall

❌ "COC is used as emergency contraception" → ✅ Only high-dose LNG or Yuzpe method (rarely used now)

📘 Topic 6: Menopause & Hormone Replacement Therapy (HRT)

🔷 Menopause Definition

- No menstruation for 12 months
- Avg. age: 51
- Diagnosis: Clinical (no labs needed >45 yrs unless atypical)

🔷 Hormonal Profile

- ↑ FSH (first to rise)
- ↓ Estrogen
- ↓ Inhibin
- LH also rises, but less dramatically

🔷 Symptoms

- Hot flashes, night sweats
- Sleep issues
- Vaginal dryness
- Mood changes, ↓ libido
- Osteoporosis risk ↑

🔷 HRT Use

- Estrogen alone: Only if no uterus (post-hysterectomy)
- Estrogen + progestin: If intact uterus (↓ endometrial cancer risk)
- Routes: Oral, transdermal, vaginal

🔷 HRT Contraindications

- Breast cancer
- Unexplained vaginal bleeding
- Active thromboembolic disease
- Liver dysfunction
- Stroke history

❌ Wrong Beliefs Corrected

- “HRT used in everyone with menopause” → ❌ Reserved for moderate to severe symptoms
- “Estrogen alone is fine if uterus present” → ❌ Needs progestin to prevent endometrial hyperplasia

📘 Topic 7: Uterine Fibroids (Leiomyoma)

🔷 Basics

- Benign smooth muscle tumor of uterus
- Estrogen-dependent
- Most common uterine tumor
- Common in reproductive age, often in African descent

🔷 Types

- Intramural (most common)
- Subserosal (can become pedunculated)
- Submucosal (most symptomatic)
- Cervical

🔷 Symptoms

- Heavy, prolonged periods (menorrhagia)
- Pelvic pressure or pain
- Infertility or miscarriage (if submucosal)
- Enlarged irregular uterus on exam

🔷 Diagnosis

- Transvaginal US = first-line
- MRI if unclear or pre-surgical planning
- Hysteroscopy for submucosal fibroids

🔷 Management

- Asymptomatic: Observe
- Medical:
  - NSAIDs, Tranexamic acid
  - GnRH agonists (temporary shrinkage)
- Surgical:
  - Myomectomy: For fertility preservation
  - Hysterectomy: Definitive if no fertility desire
  - Uterine artery embolization (UAE): for those who decline surgery

❌ "GnRH agonists are long-term solution" → ❌ Only short-term use due to hypoestrogenic effects

📘 Topic 8:

Endometriosis & Adenomyosis

🔷 Endometriosis

- Ectopic endometrial tissue outside uterus
- Sites: ovaries (endometrioma), pouch of Douglas, peritoneum
- Estrogen-dependent

Symptoms:

- Cyclical pelvic pain
- Dysmenorrhea
- Dyspareunia
- Infertility
- Tender nodularity in posterior fornix

Diagnosis:

- Clinical suspicion
- Laparoscopy = gold standard

Management:

- NSAIDs, OCPs, progestins
- GnRH analogs
- Definitive: surgery (laparoscopic excision or hysterectomy)

🔷 Adenomyosis

- Endometrial tissue within myometrium
- Common in women >40 yrs, parous
- Symptoms:
    - Heavy periods (menorrhagia)

    - Dysmenorrhea
    - Globular, uniformly enlarged tender uterus

Diagnosis:

- Transvaginal US, MRI (if needed)
- Confirmed on histopathology after hysterectomy

Management:

- NSAIDs, OCPs
- Hysterectomy = definitive

❌ Clarifications

- "Endometriosis causes heavy bleeding" → ❌ Usually cyclical pain, not always heavy flow
- "Adenomyosis causes irregular uterus" → ❌ It causes a globular, uniform enlargement

📘 Topic 9: Pelvic Inflammatory Disease (PID)

🔷 Basics

- Ascending infection of upper genital tract
- Common pathogens: Chlamydia, Gonorrhea, anaerobes

🔷 Clinical Features

- Pelvic/lower abdominal pain
- Cervical motion tenderness ("Chandelier sign")
- Fever
- Vaginal discharge
- Dyspareunia

- Adnexal tenderness ± mass (tubo-ovarian abscess)

🔷 Diagnosis

- Clinical diagnosis primarily
- Criteria:
  - Lower abdo pain + one of: cervical motion tenderness, uterine tenderness, adnexal tenderness
- Labs: ↑ WBC, ↑ ESR/CRP
- Cervical swab: NAAT for GC/Chlamydia
- US: tubo-ovarian abscess if suspected
- ❌ Laparoscopy not first-line, reserved for unclear or non-responsive cases

🔷 Management

- Outpatient:
  - Ceftriaxone IM + Doxycycline + Metronidazole
- Inpatient (IV):
  - Cefoxitin + Doxycycline
  - OR Clindamycin + Gentamicin

Complications:

- Infertility
- Ectopic pregnancy
- Chronic pelvic pain
- Tubo-ovarian abscess
- Fitz-Hugh–Curtis syndrome (perihepatitis → RUQ pain)

❌ Incorrect Beliefs

- "You must wait for culture before treating" → ❌ Treat based on clinical diagnosis
- "PID rarely affects fertility" → ❌ Recurrent PID = high infertility risk

📘 Topic 10: Infertility

🔷 Definitions

- Infertility: No pregnancy after 12 months unprotected sex
  - Primary = never conceived
  - Secondary = had prior pregnancy

🔷 Female Causes (Most Common to Least)

1. Ovulatory dysfunction (e.g. PCOS)
2. Tubal factors (e.g. PID, endometriosis)
3. Uterine factors (e.g. fibroids, adhesions)
4. Cervical mucus factors

🔷 Male Factors

- Low sperm count (oligospermia)
- Low motility (asthenospermia)
- Morphological defects
- Hormonal (hypogonadism, Kallmann)
- Obstruction

🔷 Evaluation

- Female:
  - Ovulation check: mid-luteal progesterone (Day 21)
  - Pelvic US
  - Hysterosalpingography (HSG) to assess tubal patency
- Male:
  - Semen analysis (2 samples, 2–5 days abstinence)

❌ Clarifications

- "Semen analysis comes later" → ❌ Do it early — male factor = 40–50%
- "Ovulation = positive LH kit" → ✅ But confirm with progesterone Day 21

📘 Topic 11: Benign Ovarian Tumors

🔷 Types (Grouped by Tissue Origin)

1. Epithelial
   - Serous cystadenoma (most common benign epithelial tumor)
   - Mucinous cystadenoma (can grow huge)
   - Brenner tumor
2. Germ Cell
   - Dermoid cyst (mature teratoma): most common benign ovarian tumor in young women
     - Contains hair, teeth, skin, etc.
     - Risk of torsion
     - Can cause thyroid dysfunction (struma ovarii)

3. Sex cord–stromal
    - Fibroma: may cause ascites + pleural effusion → Meigs syndrome
    - Thecoma, Granulosa cell tumor: estrogen-secreting

🔷 Clinical Presentation

- Most asymptomatic
- Pelvic pain, mass, fullness
- Torsion → sudden pain
- ↑ Risk in large cysts, mobile masses, dermoids

🔷 Diagnosis

- US = first-line
    - Benign = unilocular, thin-walled, no solid parts
- Tumor markers (CA-125, AFP, LDH) if suspicious

🔷 Management

- Observation if:
    - Simple, <5 cm, premenopausal, asymptomatic
- Surgical removal if:
    - Large, symptomatic, postmenopausal, or complex on imaging

❌ Misconceptions Fixed

- "Dermoid cysts don't cause torsion" → ❌ They're most likely to twist
- "All ovarian tumors are solid" → ❌ Benign tumors often cystic and simple

📘 Topic 12: Malignant Ovarian Tumors

🔷 Epithelial Tumors (Most Common Overall)

- Serous cystadenocarcinoma = most common malignant type
- Postmenopausal women
- Often bilateral
- Spread via peritoneal seeding

🔷 Germ Cell Tumors (Young Women)

- Dysgerminoma
  - ↑ LDH
  - Most common malignant germ cell tumor
  - Radiosensitive
- Endodermal sinus (Yolk sac tumor): ↑ AFP
- Choriocarcinoma (non-gestational): ↑ β-hCG
- Immature teratoma: Aggressive

🔷 Sex Cord–Stromal Tumors

- Granulosa cell tumor
  - Estrogen-producing
  - May cause precocious puberty or postmenopausal bleeding
  - Call-Exner bodies on histology
- Sertoli-Leydig: Androgen-producing → virilization

🔷 Risk Factors for Malignancy

- Nulliparity
- Early menarche, late menopause
- Family history (BRCA1/2)
- Endometriosis (for clear cell type)

🔷 Diagnosis

- US: Multiloculated, solid areas, papillary projections
- CA-125: Marker for epithelial tumors (used in postmenopausal women)
- CT/MRI for staging

🔷 Management

- Surgery = primary treatment
- Chemo if advanced (esp. germ cell tumors)
- Fertility-sparing surgery possible in early-stage germ cell tumors

❌ Common Errors Corrected

- "CA-125 reliable in young women" → ❌ Not specific premenopausally
- "Dermoid = malignant in all cases" → ❌ Mature teratomas are benign
- "Dysgerminoma is treated with surgery only" → ❌ It's also radiosensitive

📘 Topic 13: Cervical Cancer

🔷 Cause & Risk Factors

- 99% caused by HPV (types 16, 18 = high-risk)
- RFs:
  - Early sexual activity
  - Multiple partners
  - Smoking
  - Immunosuppression
  - Low socioeconomic status
  - No regular Pap screening

🔷 Screening (Pap + HPV)

Age	Recommended Action
<21 yrs	No screening
21–29 yrs	Pap smear every 3 yrs
30–65 yrs	Pap + HPV every 5 yrs (or Pap q3y)
>65 yrs	Stop if 3 normal Paps & no risk
Post-hysterectomy (benign)	No screening needed

🧠 HPV testing more useful in women ≥30 yrs

🔷 Precursor Lesions

- CIN 1: Mild dysplasia → observe
- CIN 2–3: High-grade → treat
- Diagnosis via colposcopy + biopsy

🔷 Diagnosis of Cancer

- Pap smear → Colposcopy → Biopsy
- If abnormal → punch biopsy
- For staging: MRI or clinical exam (FIGO system)
- Staging is clinical, not surgical

🔷 Management

- CIN 1: Observation
- CIN 2/3: Excision (LEEP, cryo, laser)
- Early cancer: Surgery (radical hysterectomy)
- Advanced: Chemoradiation
- ❌ "CIN 1 always needs surgery" → ❌ Often regresses spontaneously

📘 Topic 14: Endometrial Cancer

🔷 Risk Factors (Anything Estrogen!)

- Unopposed estrogen therapy
- Obesity
- PCOS (chronic anovulation)
- Early menarche, late menopause
- Nulliparity
- Tamoxifen
- Lynch syndrome (HNPCC)

🔷 Clinical Clue

- Postmenopausal bleeding = endometrial cancer until proven otherwise
- Premenopausal: heavy/irregular bleeding

🔷 Diagnosis

- TVUS: If endometrial stripe >4 mm postmenopause → investigate
- Endometrial biopsy: definitive
- Hysteroscopy + D&C if biopsy inconclusive

🔷 Management

- Stage I–II: Total hysterectomy + BSO ± radiation
- Stage III–IV or high grade: Add chemo/radiation
- Progestins for early-stage + fertility desire

❌ Clarifications

- "Tamoxifen protects uterus" → ❌ It stimulates endometrium
- "Postmenopausal bleeding is usually benign" → ❌ Always investigate

📘 Topic 15: Vulvar & Vaginal Cancer

🔷 Vulvar Cancer

- Most common in elderly postmenopausal women
- Squamous cell carcinoma = most common type
- HPV-associated (types 16, 18) in younger women
- Non-HPV-related: Chronic inflammation (e.g. lichen sclerosus)

Symptoms:

- Vulvar itching, pain, or visible lesion
- Ulcerated, raised, or pigmented lesion

Diagnosis:

- Biopsy (any suspicious lesion)
- Staging = surgical (based on lymph node involvement)

Treatment:

- Wide local excision
- Radical vulvectomy + lymphadenectomy (if invasive)

❌ "HPV unrelated to vulvar cancer" → ❌ HPV is a cause, especially in young women

🔷 Vaginal Cancer

- Rare, usually secondary spread
- Squamous cell most common
- Clear cell adenocarcinoma → associated with DES exposure in utero

Symptoms:

- Postmenopausal bleeding
- Vaginal discharge
- Vaginal mass

Diagnosis: Biopsy

Treatment: Radiation ± surgery depending on stage

❌ "DES exposure affects ovaries" → ❌ Linked to vaginal clear cell cancer

📘 Topic 16: Pelvic Organ Prolapse & Urinary Incontinence

🔷 Types of Prolapse

- Cystocele: Bladder bulges into anterior vaginal wall
- Rectocele: Rectum into posterior vaginal wall
- Enterocele: Small bowel into upper posterior vagina
- Uterine prolapse: Descent of uterus through vagina
- Vault prolapse: Post-hysterectomy vaginal apex descent

Symptoms:

- Vaginal bulge or pressure
- Urinary issues
- Constipation
- Back pain

Management:

- Pelvic floor exercises
- Pessaries
- Surgery (hysterectomy, sacrocolpopexy)

🔷 Urinary Incontinence Types

Type	Key Feature	First-line Treatment
Stress	Leak with cough/sneeze/exercise	Pelvic floor exercises (Kegels), surgery if severe
Urge	Sudden urge, can’t hold	Bladder training, anticholinergics (oxybutynin)
Overflow	Dribbling, incomplete emptying	Catheterization, treat cause (e.g. diabetes, BPH)
Functional	Normal urinary system but can’t reach toilet	Environment/support changes

❌ Common Errors Fixed

- "Urge incontinence treated with surgery first" → ❌ Conservative meds first
- "Cystocele = bowel bulge" → ❌ It's the bladder, rectocele is bowel

📘 Topic 17: Sexually Transmitted Infections (STIs)

🔷 Chlamydia trachomatis

- Most common STI overall
- Often asymptomatic
- Can cause cervicitis, PID, infertility, ectopic pregnancy
- Diagnosis: NAAT (vaginal/cervical swab or urine)
- Treatment: Doxycycline 100 mg BID × 7 days (or Azithromycin if pregnant)

🔷 Neisseria gonorrhoeae

- Often co-infects with Chlamydia
- Purulent discharge, cervicitis, PID
- Diagnosis: NAAT
- Treatment: Ceftriaxone 500 mg IM + Doxycycline (for Chlamydia coverage)

🔷 Herpes Simplex Virus (HSV)

- Painful grouped vesicles, ulcers
- Systemic symptoms in primary infection
- Diagnosis: Clinical, PCR or culture from lesion
- Treatment: Acyclovir
- ❌ "Antibiotics cure herpes" → ❌ It's viral, treat with antivirals

🔷 Syphilis (Treponema pallidum)

- Primary: Painless chancre
- Secondary: Rash (palms/soles), condylomata lata
- Latent/tertiary: Neuro/cardiovascular involvement
- Diagnosis: RPR, confirmed by FTA-ABS
- Treatment: Benzathine penicillin G IM
- ❌ "Syphilitic ulcers are painful" → ❌ They are painless

🔷 Condyloma acuminata (HPV 6, 11)

- Warty growths, painless
- Diagnosis: Clinical
- Treatment: Cryotherapy, imiquimod, excision
- Prevented by HPV vaccine

📘 Topic 18: Vulvovaginal Infections

Infection	Discharge	pH	Odor	Microscopy	Treatment
Candida	Thick, white, curdy	<4.5	No odor	Pseudohyphae	Fluconazole (oral/ suppository)
BV	Thin, gray-white	>4.5	Fishy	Clue cells, + whiff test	Metronidazole (oral/gel)
Trichomonas	Frothy, yellow-green	>4.5	Bad smell	Motile protozoa on wet mount	Metronidazole (treat partner too)

🧠 Candida = itchy, BV = fishy, Trich = frothy

❌ Common Errors Clarified

- "BV has thick discharge" → ❌ It's thin and gray-white
- "All need partner treatment" → ❌ Only Trichomonas requires partner treatment
- "Candida pH is high" → ❌ pH is normal or low (<4.5)

🧬 FINAL HIGH-YIELD REVISION — GYNECOLOGY

👨‍⚕️ Puberty & Menstrual Physiology

- First sign of puberty: Thelarche (breast budding)
- Menarche average age: ~12.5 years (2–3 years after thelarche)
- Ovulation: Day 14 of 28-day cycle
- Luteal phase: Dominated by progesterone, NOT estrogen ❌
- Ovulation trigger: LH surge
- Menstruation: Caused by drop in estrogen + progesterone

🚫 Amenorrhea

- Primary: No menses by age 13 (no secondary sex traits) or 15 (with them)
- Most common secondary cause: Pregnancy (always rule out first)
- Workup order: hCG → TSH/Prolactin → Progesterone Challenge → FSH/LH
- Asherman syndrome: Secondary amenorrhea + intrauterine adhesions
- ✅ Corrected: Don't jump to MRI — only if hypothalamic/pituitary issue suspected

🥚 Polycystic Ovary Syndrome (PCOS)

- Most common cause of anovulatory infertility
- Criteria: Need 2 of 3 (oligo/anovulation, hyperandrogenism, polycystic ovaries)
- Hormones: ↑ LH:FSH (>2:1), ↑ androgens, ↑ estrogen (peripheral), FSH low/normal
- USG: “String of pearls” (≥12 follicles, >10 cm^3 volume)
- First-line fertility drug: Letrozole ✅ (better than clomiphene)

🧠 Hyperprolactinemia

- Most common cause: Prolactinoma
- Drugs: Antipsychotics, metoclopramide
- Symptoms: Galactorrhea, amenorrhea, ↓ libido
- First-line treatment: Dopamine agonists (Cabergoline, Bromocriptine)
- ✅ Corrected: Do NOT start with surgery unless macroadenoma + vision loss

💊 Contraception

- COCs contraindications (ACHES): Abdominal pain, Chest pain, Headache, Eye problems, Severe leg pain
- Progestin-only pill: Best for breastfeeding; thickens cervical mucus
- Copper IUD: Most effective emergency contraception (<5 days)
- ✅ Corrected: COCs ≠ emergency contraception by default

🔥 Menopause & HRT

- Average age: 51 years
- First hormone to rise: FSH 📈

- HRT:
  - Estrogen alone → only if no uterus
  - Estrogen + progestin → if uterus present
- ✅ Corrected: HRT only for moderate to severe symptoms; estrogen alone without uterus

🩸 Uterine Fibroids

- Most common uterine tumor
- Types:
  - Intramural: Most common
  - Submucosal: Most symptomatic
- Symptoms: Menorrhagia, pressure, infertility
- US = 1st line, MRI if unclear
- GnRH agonists: Short-term only (pre-op shrinkage)
- ✅ Corrected: Not for long-term use due to hypoestrogenism

🩺 Endometriosis vs Adenomyosis

Endometriosis

- Most common site: Ovary (endometrioma)
- Classic triad: Cyclical pain, dyspareunia, infertility
- Gold standard dx: Laparoscopy
- ✅ Corrected: Does not usually cause heavy bleeding

Adenomyosis

- Globular uniformly enlarged uterus
- Classic: Women >40, heavy painful periods

- Confirmed: Histopathology post-hysterectomy
- ✅ Corrected: Not irregular enlargement, but uniform

🦠 Pelvic Inflammatory Disease (PID)

- Most common pathogens: Chlamydia, Gonorrhea
- Signs: Cervical motion tenderness (“chandelier sign”), fever, discharge
- Diagnosis: Clinical + NAAT (GC/Chlamydia)
- Complications: Infertility, chronic pain, Fitz-Hugh–Curtis
- ✅ Corrected: Do not delay treatment waiting for cultures

👶 Infertility

- Definition: No conception after 12 months unprotected sex
- Most common female cause: Ovulatory dysfunction (e.g., PCOS)
- Most common male workup step: Semen analysis — do early!
- Confirm ovulation: Day 21 progesterone

🥥 Benign Ovarian Tumors

- Most common benign overall: Dermoid cyst (teratoma)
- Risk of torsion: Highest with dermoid
- Meigs syndrome: Fibroma + ascites + pleural effusion
- ✅ Corrected: Not all tumors are solid; many are cystic

🧬 Malignant Ovarian Tumors

- Most common type: Serous cystadenocarcinoma (epithelial)
- Germ cell tumor in young women: Dysgerminoma (↑ LDH)

- Sex cord-stromal: Granulosa cell (↑ estrogen, Call-Exner bodies)
- CA-125: Not useful in young women (low specificity)
- ✅ Corrected: Dysgerminoma is also radiosensitive, not surgery alone

👄 Cervical Cancer

- Cause: HPV 16, 18
- Most common site: Squamous cell (ectocervix)
- Screening:
  - <21: none
  - 21–29: Pap q3y
  - 30–65: Pap + HPV q5y
- Management: Based on CIN level; early = excision, advanced = chemoradiation

🏛️ Endometrial Cancer

- Classic symptom: Postmenopausal bleeding = cancer until proven otherwise
- Risk factors: Estrogen exposure, obesity, PCOS, Tamoxifen, Lynch
- Diagnosis: TVUS (>4 mm stripe), biopsy definitive
- Treatment: Hysterectomy + BSO ± radiation
- ✅ Corrected: Tamoxifen stimulates, not protects, endometrium

🛑 Vulvar & Vaginal Cancer

- Vulvar SCC = most common, esp. postmenopausal
- Young women: HPV 16/18 link
- Vaginal clear cell carcinoma: DES exposure in utero
- Diagnosis: Biopsy all suspicious lesions

⬇️ Pelvic Organ Prolapse & Incontinence

- Cystocele = bladder, not bowel
- Urge incontinence: Anticholinergics (Oxybutynin)
- Stress incontinence: Kegels → surgery if needed
- ✅ Corrected: Surgery not 1st line for urge incontinence

💥 STIs & Vulvovaginal Infections

- Most common STI overall: Chlamydia
- Syphilis: Painless chancre → Rash on palms/soles
- HSV: Painful grouped vesicles
- Trichomonas: Treat partner; frothy yellow-green discharge
- BV: Thin, fishy, clue cells
- Candida: Thick, curdy, pseudohyphae, normal pH