1 PATIENT INFORMATION

1 PATIENT DETAILS

NAME
Adaeze N. Okonkwo-Bright

DOB
09/28/1982

AGE / SEX
43 yrs / Female

MRN / PATIENT ID
OB-62481

DATE OF SERVICE
08/19/2026

PROVIDER
Serena L. Whitcomb, MD

CREDENTIALS
MD, FACOG

PRIMARY CARE PROVIDER
Devon Marsh, MD

VISIT TYPE
Gynecology consultation — abnormal uterine bleeding with same-visit endometrial biopsy

CARE SETTING
Outpatient OB-GYN Clinic, hospital-affiliated women's health center

REFERRING PROVIDER
Primary care — heavy bleeding with iron deficiency anemia

INTERPRETER USED
None required

CHAPERONE PRESENT
Yes — Marisol Vega, MA, present for the breast, pelvic, and biopsy portions

CC CHIEF COMPLAINT

2 PRIMARY OBSTETRIC OR GYNECOLOGIC CONCERN

"My periods have gotten out of control. I'm soaking through a super tampon and a pad every hour on my worst days, I've passed clots the size of a plum, and I'm so tired I had to leave a deposition early last month. I've also had bleeding between periods, which is new."

S SUBJECTIVE

3 GYNECOLOGIC, OBSTETRIC, REPRODUCTIVE & PREVENTIVE HISTORY

3a REASON FOR VISIT & PRESENT ILLNESS

Reason for OB-GYN Evaluation

Consultation for abnormal uterine bleeding — heavy menstrual bleeding with new intermenstrual bleeding in a 43-year-old with symptomatic iron deficiency anemia, referred by primary care. Purposes of the visit: characterize the bleeding, evaluate for structural and endometrial causes including malignancy, perform endometrial sampling, and begin treatment. Contraception and preconception intentions also addressed.

History of Present Illness

Cycles were regular and predictable until approximately 20 months ago. Since then, flow has become progressively heavier and now lasts 8–9 days (previously 4–5). On days 2–3 she saturates a super tampon plus an overnight pad hourly for 5–7 consecutive hours, passes clots up to 3–4 cm, and floods overnight through bedding roughly once per cycle. Over the past 5 months she has developed **intermenstrual bleeding** — 2–4 days of light-to-moderate bleeding around mid-cycle, occurring in 4 of the last 5 cycles. This is the symptom that prompted referral and is the one that most concerns her. Associated symptoms: progressive fatigue, exertional dyspnea climbing two flights, lightheadedness on standing, palpitations on heavy days, pica (she has been chewing ice compulsively for 4 months), and cold intolerance. She left a work deposition early in 07/2026 because of flooding and near-syncope — a functional impact she reports as unacceptable. Prior evaluation: primary care obtained a CBC and ferritin in 06/2026 (below) and started oral iron; no imaging, no endometrial sampling, and no hormonal therapy have been tried. Tranexamic acid and NSAIDs have not been offered.

Menstrual History

Menarche age 11. Last menstrual period 07/31/2026 (day 20 of the current cycle today). Cycles now 24–33 days — more variable than her lifelong 28–29 days. Bleeding duration 8–9 days. Flow heavy with clots and flooding as above; pictorial blood loss assessment chart score 210 (severe; threshold for menorrhagia is 100). Dysmenorrhea moderate, 6/10 on days 1–2, responsive to ibuprofen, and worse than in prior years. Intermenstrual bleeding as described. **No postcoital bleeding.** No amenorrhea. Perimenopausal features present — cycle-length variability, occasional night sweats 1–2 nights weekly for 6 months — but she is not menopausal and has not had 12 months of amenorrhea.

3b PREGNANCY, PRENATAL & POSTPARTUM

Pregnancy Status / Obstetric History

Not pregnant — urine hCG negative today (documented below). G3 P2012. Spontaneous vaginal delivery 2011 at 39+4, female, 3,410 g, uncomplicated. Spontaneous vaginal delivery 2014 at 38+2, male, 3,290 g, complicated by a 700 mL postpartum hemorrhage from uterine atony managed medically without transfusion or surgery. One first-trimester miscarriage in 2016 at 8 weeks, managed expectantly, no dilation and curettage. No ectopic pregnancy, no terminations, no cesarean delivery, no preterm birth. No current pregnancy concerns.

Prenatal Symptoms

Not applicable — not pregnant this visit.

Postpartum History

Not applicable — last delivery 2014. Noted for completeness that she breastfed both children for approximately 11 months each without complication, and that her 2014 postpartum hemorrhage is relevant to her overall bleeding history and to any future surgical planning.

3c PELVIC, VULVOVAGINAL, URINARY & BREAST

Pelvic Pain Symptoms

Cyclic suprapubic cramping 6/10 on days 1–2 of menses, dull and pressure-like, radiating to the low back, relieved partially by ibuprofen and a heating pad. Additionally, a new non-cyclic sensation of pelvic heaviness and fullness for about a year, worse by the end of the workday and when standing for long periods. No pain with urination or bowel movements. **No deep dyspareunia** and no pain that peaks premenstrually and resolves with menses (asked specifically — the pattern that would raise suspicion for endometriosis). No fever, no unilateral acute pain, no nausea or vomiting with the pain.

Vaginal / Vulvar Symptoms

No abnormal discharge, odor, itching, burning, or irritation. Mild vaginal dryness for approximately 8 months, noticeable with intercourse but not painful enough to avoid it — consistent with early perimenopausal change. No lesions or ulcers. No new soaps, douches, or topical products; she reports no douching. No prior vulvovaginal infections in over a decade.

Urinary Symptoms

Urinary frequency has increased over the past year — approximately 9–10 daytime voids and 1–2 nocturnal voids, up from 6 and 0. She attributes it to "pressure." No dysuria, no urgency incontinence, no stress leakage, no hematuria (distinguished carefully from vaginal bleeding), no flank pain. No UTI in over 5 years. The frequency pattern without infective symptoms is consistent with extrinsic bladder compression.

Breast Symptoms

No breast pain, mass, nipple discharge, or skin change. Performs occasional self-examination. Last mammogram 03/2025 — BI-RADS 1, negative; she is due for her next screening. No prior breast biopsy. Family history significant and detailed below, which affects her screening and genetic risk assessment.

3d SEXUAL HEALTH, CONTRACEPTION & MENOPAUSE

Sexual and Reproductive Health

Sexually active with one long-term male partner of 14 years, monogamous by mutual report. No new partners in over a decade. Mild superficial dryness-related discomfort with intercourse, no deep dyspareunia. Libido reduced over the past year, which she attributes to fatigue rather than to relationship factors. Low STI risk; last screening 2021, negative. **Pregnancy intentions: childbearing complete** — she is certain and has discussed permanent options with her partner, who has also considered vasectomy. No condom use. Screened for safety: she reports feeling safe at home and in her relationship, denies coercion regarding contraception or pregnancy, and denies any history of intimate partner violence.

Contraception History

Currently using no contraception; the couple has relied on withdrawal and perceived reduced fertility, and she acknowledges the pregnancy risk. Prior methods: combined oral contraceptives ages 19–27, discontinued for breakthrough bleeding and nausea; copper IUD 2015–2018, removed because it worsened her bleeding and cramping (an important detail — it makes a copper device a poor choice now); condoms intermittently. No emergency contraception needed. **Strongly interested in a levonorgestrel IUD** after learning it treats heavy bleeding as well as preventing pregnancy, and open to discussing permanent contraception for either partner. No estrogen contraindication identified — she does not smoke and has no migraine with aura, thrombosis history, or uncontrolled hypertension.

Menopause / Hormonal Symptoms

Night sweats 1–2 nights weekly for 6 months, mild and not sleep-disrupting most nights. Occasional daytime flushing, roughly twice weekly. Vaginal dryness as above. Mood more labile premenstrually than previously. Sleep fragmented, though she attributes this largely to anemia-related restlessness and to nocturia. No hormone therapy used. No non-hormonal treatments tried. She is perimenopausal by symptom pattern and cycle variability, but abnormal bleeding at 43 must not be attributed to perimenopause without excluding structural and endometrial disease — explicitly discussed with her.

3e MEDICAL, FAMILY & SOCIAL CONTEXT

Gynecologic History

Pap and HPV co-test 04/2024: negative cytology, HPV-negative — next due 2029. No history of abnormal cytology, colposcopy, LEEP, or cone biopsy. **Fibroids first noted on a 2018 ultrasound** obtained at the time of her IUD removal and described then as two intramural fibroids of 2 and 3 cm, considered incidental; not re-imaged since. No endometriosis diagnosis and no prior laparoscopy. No ovarian cysts. No pelvic inflammatory disease, no STIs. No gynecologic surgery of any kind. No prior endometrial sampling.

Past Medical and Surgical History

Iron deficiency anemia (current, secondary to menorrhagia). Well-controlled hypertension since 2021 on lisinopril. Class I obesity (BMI 31.4). Vitamin D insufficiency. No diabetes — HbA1c 5.4% in 2026. No thyroid disease (TSH normal, below). No clotting disorder, no deep vein thrombosis or pulmonary embolism, no stroke. **No migraine with aura** — asked specifically for estrogen eligibility; she has occasional tension headaches only. No cancer history. No autoimmune disease. Surgical history: wisdom teeth extraction 2003 and a laparoscopic cholecystectomy in 2019 with no bleeding complication and no anesthetic problem. No known drug allergies.

Medication History and Treatment Response

Lisinopril 20 mg daily (adherent, BP well controlled). Ferrous sulfate 325 mg daily started 06/2026 by primary care — she

reports constipation and nausea and has been taking it roughly every other day, so effective adherence is about 50%. Ibuprofen 400–600 mg PRN for cramps, which she takes only for pain and not scheduled through her flow (a missed therapeutic opportunity, since scheduled NSAIDs reduce blood loss). Vitamin D3 1,000 IU daily. No hormonal medication, no tranexamic acid, no anticoagulant, no aspirin, no herbal or over-the-counter supplements. Employer insurance with good coverage; no medication cost barrier.

Family History

Mother: endometrial cancer at 58, treated surgically, alive at 71. **Maternal aunt: colon cancer at 46.** Maternal grandmother: uterine cancer, age not known, deceased. Father: type 2 diabetes and hypertension. Sister, 46: fibroids with a hysterectomy at 42. No known breast or ovarian cancer, no known BRCA. No clotting disorders. No early menopause. This constellation — endometrial cancer in a first-degree relative, early-onset colon cancer in a second-degree relative, and a second uterine cancer — meets criteria to consider **Lynch syndrome** and materially raises her endometrial cancer risk.

Social History / Safety

Attorney, full-time, high work demands. Never smoked. Alcohol 2–4 glasses of wine weekly. No cannabis or other substance use. Lives with her partner and two children (ages 15 and 12). Strong support system. Owns her home, stable housing, reliable transportation, no food insecurity. Intimate partner violence screening negative — feels safe, no coercion. No occupational exposures. Health literacy high; she came with a written symptom and product-use log covering three cycles.

Pertinent Negatives

Denies syncope (near-syncope only), fever, chills, and severe or acute pelvic pain. No shoulder-tip pain and no concern for pregnancy — hCG negative. No severe headache or vision changes. No chest pain; the exertional dyspnea and palpitations are anemia-related and resolve at rest. No unilateral leg swelling, calf pain, or thrombosis symptoms. No postcoital bleeding. No unintentional weight loss, no night sweats of the drenching constitutional type, no abdominal or pelvic mass noticed by the patient. No bowel obstruction symptoms. No depression or suicidal ideation on screening.

ROS OB-GYN REVIEW OF SYSTEMS

4 PERTINENT POSITIVES & NEGATIVES

Menstrual	**Positive: heavy menstrual bleeding (PBAC 210), 8–9 day flow, clots to 4 cm, flooding, cycle variability 24–33 days, and new intermenstrual bleeding in 4 of 5 cycles. Negative for postcoital bleeding and amenorrhea.**
Pelvic	**Positive: cyclic dysmenorrhea 6/10, non-cyclic pelvic heaviness and fullness worse with standing. Negative for deep dyspareunia, acute or unilateral pain, and premenstrual pain peaking pattern.**
Vulvovaginal	**Positive: mild vaginal dryness with superficial discomfort. Negative for discharge, odor, itching, burning, lesions.**
Urinary	**Positive: increased frequency (9–10 daytime, 1–2 nocturnal voids) attributed to pressure. Negative for dysuria, urgency, incontinence, hematuria, flank pain.**
Breast	**Negative for pain, mass, nipple discharge, and skin change. Mammogram 03/2025 BI-RADS 1; next screening due.**
Constitutional / anemia	**Positive: progressive fatigue, exertional dyspnea, lightheadedness on standing, palpitations on heavy days, pica (ice chewing), cold intolerance. Negative for**

	syncope, fever, and unintentional weight loss.
Menopausal	**Positive: night sweats 1–2 nights weekly, occasional flushing, vaginal dryness, premenstrual mood lability. Negative for 12 months of amenorrhea.**
Sexual health and contraception	**Positive: reduced libido attributed to fatigue, no current contraception with acknowledged pregnancy risk, interest in a levonorgestrel IUD. Negative for STI symptoms and for new partners.**
Mood and safety	**Negative for depression (PHQ-9 4), anxiety (GAD-7 3), suicidal ideation, and intimate partner violence. Positive for work and quality-of-life impact from bleeding.**

O OBJECTIVE

5 OBSERVED FINDINGS

V VITALS

TEMPERATURE
98.3 °F

BLOOD PRESSURE
128/80 mmHg (seated); 118/74 standing, no orthostatic drop

HEART RATE
92 bpm, regular

RESPIRATORY RATE
16/min

OXYGEN SATURATION
98% on room air

HEIGHT
5′ 5″ (165 cm)

WEIGHT
189 lb (85.7 kg)

BMI
31.4 kg/m²

PAIN SCORE
1/10 today (day 20, not menstruating)

GESTATIONAL AGE
Not applicable — urine hCG negative

FETAL HEART RATE
Not applicable

5a GENERAL & SYSTEMIC EXAMINATION

General Appearance

Alert, articulate, no acute distress. Well groomed, appropriately dressed. Mild conjunctival and palmar pallor. Obese habitus with central distribution. Ambulates independently without difficulty. Engaged and organized — presented a written three-cycle bleeding log.

Cardiovascular

Rate 92 and regular, S1 and S2 normal. **Soft grade 1–2/6 systolic flow murmur at the left upper sternal border** without radiation — consistent with the high-output physiology of anemia and expected to resolve with correction; no diastolic murmur, no click, no rub. Radial and pedal pulses 2+ and symmetric. Capillary refill brisk. No peripheral edema. No jugular venous distension. **No calf tenderness, asymmetry, or cords** — documented before starting hormonal therapy.

Pulmonary

Normal effort at rest. Clear to auscultation bilaterally, no wheeze or crackles. No accessory muscle use. Room air, saturation 98%. Mild dyspnea reported on exertion only, not reproduced at rest.

Abdomen

Obese, soft, non-distended. **Firm, irregular, non-tender midline mass palpable arising from the pelvis and extending approximately 4 cm above the pubic symphysis**, mobile with the cervix on bimanual correlation, consistent with an enlarged fibroid uterus. No guarding, rebound, or peritoneal signs. No hepatosplenomegaly. Bowel sounds normal. Well-healed laparoscopic port scars from the 2019 cholecystectomy. No hernia. No ascites, no fluid wave, and no shifting dullness — assessed given the pelvic mass.

5b BREAST & PELVIC EXAMINATION

Breast Exam

Performed with the chaperone present and with the patient's verbal consent. Breasts symmetric without skin dimpling, retraction, peau d'orange, or erythema. No palpable mass, thickening, or nodularity in any quadrant bilaterally. Nipples everted, no discharge on gentle expression, no crusting or excoriation. No axillary, supraclavicular, or infraclavicular lymphadenopathy. Examination not limited by breast density or tenderness.

Pelvic Exam

Performed with the chaperone present, with consent, and with each step explained in advance. External genitalia: normal hair distribution, no lesions, ulcers, condylomata, or excoriation; Bartholin and Skene glands unremarkable; urethral meatus normal without caruncle or prolapse. Vulvar and vaginal mucosa mildly pale and less rugated with reduced elasticity — mild atrophic change consistent with perimenopause. No cervical motion tenderness. Pelvic floor: normal tone, no levator tenderness, no anterior, apical, or posterior compartment descent on Valsalva. Patient tolerated the examination well; no limitations.

Speculum Exam

Vaginal walls pink with mild pallor, no lesions, no erosion, no discharge beyond scant physiologic secretions. Cervix parous with a slit-like os, smooth and non-friable, no visible polyp at the os, no ectropion, no ulceration, and no contact bleeding on manipulation — the cervix is not the bleeding source. Scant dark blood in the posterior fornix consistent with the reported intermenstrual bleeding. No IUD strings (device removed 2018). No pooling, no nitrazine or ferning testing indicated. Specimens collected: endocervical gonorrhea and chlamydia nucleic acid amplification (low risk, but obtained before instrumentation), and a wet mount — results below. Pap not repeated (negative co-test 04/2024, next due 2029).

Bimanual Exam

Uterus anteverted, **markedly enlarged and irregularly contoured, estimated at 14–16 week gravid size**, with two discrete firm protuberances palpable on the fundal and left lateral surfaces. Mobile, non-tender, no fixation to surrounding structures. Cervix firm, non-tender, no cervical motion tenderness. Adnexa: no mass or tenderness on the right; the left adnexa is partially obscured by the enlarged uterus and could not be fully assessed — a stated limitation that imaging resolves. No cul-de-sac nodularity or tenderness (assessed for endometriosis). No parametrial induration. Rectovaginal examination deferred — not indicated in the absence of posterior findings or bowel symptoms.

5c EXTREMITIES, SKIN & PSYCHIATRIC

Extremities

No edema. No calf tenderness, swelling, asymmetry, or palpable cords. Mild varicosities in the left lower leg, chronic and unchanged. No cyanosis or clubbing. Koilonychia absent; nail beds pale.

Skin

Mild generalized pallor, most evident in the conjunctivae, palmar creases, and nail beds. No rash, purpura, petechiae, or ecchymoses — specifically examined given heavy bleeding, and their absence argues against a systemic bleeding disorder. Well-healed laparoscopic scars. No striae of recent onset. No acanthosis nigricans. No hirsutism.

Psychiatric

Mood appropriate, affect full and reactive. Cooperative, organized, and articulate historian. Insight and judgment intact. Understandably anxious about the possibility of cancer given her family history, and she raised it herself; she asked direct questions and was able to engage in shared decision-making. PHQ-9 4, GAD-7 3. No hopelessness, no suicidal ideation,

no safety concerns.

PA PRENATAL ASSESSMENT

6 PREGNANCY-SPECIFIC FINDINGS & MONITORING

Applicability	**Not applicable this visit — patient is not pregnant (urine hCG negative 08/19/2026) and childbearing is complete. Section retained to document that pregnancy was actively excluded before endometrial instrumentation and before initiating hormonal therapy.**
Rh status	**A positive (from 2014 delivery records) — recorded; no Rh immune globulin considerations.**
Contraceptive need in place of prenatal care	**Present and unmet — she is 43, ovulating, sexually active, using no method, and does not desire pregnancy. Addressed directly in the plan rather than deferred.**

PC PREVENTIVE CARE / SCREENING

7 PREVENTIVE NEEDS & COMPLETED ITEMS

Pap smear and HPV screening	**Co-test 04/2024 — cytology negative, HPV negative. Up to date; next due 2029. Not repeated today.**
STI screening	**Endocervical gonorrhea and chlamydia obtained today before instrumentation (low risk, monogamous 14 years; last screen 2021 negative). HIV and syphilis offered and accepted — ordered.**
Hepatitis and other infectious screening	**Hepatitis C one-time adult screening completed 2022, negative. Hepatitis B surface antigen negative (2014 prenatal record). Trichomonas assessed on wet mount — negative.**
Breast cancer screening	**Mammogram 03/2025, BI-RADS 1. Due now — ordered today. Clinical breast exam performed and normal. Risk assessment warranted given family history, though no breast or ovarian cancer is reported.**
Colon cancer screening	**Overdue and clinically important. Never screened. Age 43 with a maternal aunt who had colon cancer at 46 and a first-degree relative with endometrial cancer — colonoscopy indicated now rather than at 45, and earlier still if Lynch syndrome is confirmed. Referral placed.**
Bone density screening	**Not indicated — age 43, no fracture, no glucocorticoid use, no early menopause. Reassess after menopause.**
Contraception counseling	**Delivered in full — see plan. Levonorgestrel IUD, permanent contraception for either partner, and interim options reviewed with efficacy and bleeding effects.**
Preconception counseling	**Not applicable — childbearing complete and confirmed**

	with the patient.
Immunizations	**Influenza due (offered, accepted for the fall). Tdap 2019, current. COVID-19 booster due — offered. HPV vaccination not given (age 43, not routinely indicated; discussed and declined). Rubella immune and varicella immune per 2014 prenatal labs.**
Intimate partner violence screening	**Performed privately with the chaperone stepped out — negative. Feels safe at home; no coercion regarding contraception or pregnancy; no history disclosed.**
Depression and anxiety screening	**PHQ-9 4 (minimal), GAD-7 3 (minimal). Situational worry about malignancy noted and addressed directly with information.**
Postpartum depression screening	**Not applicable.**
Lifestyle counseling	**Nutrition (iron-rich foods with vitamin C, reducing tea and calcium at dosing times), physical activity as tolerated once anemia improves, never-smoker reinforced, alcohol 2–4 drinks weekly reviewed within limits, sleep, and work-pacing during heavy days.**

PR PROCEDURES PERFORMED

8 PROCEDURE DOCUMENTATION — ENDOMETRIAL BIOPSY

Procedure, indication, consent, pregnancy status, chaperone, anesthesia

Endometrial biopsy (Pipelle aspiration), performed this visit. Indication: abnormal uterine bleeding with intermenstrual bleeding in a 43-year-old with a first-degree relative with endometrial cancer, obesity, and possible Lynch syndrome — all raising endometrial cancer risk sufficiently to require tissue diagnosis regardless of imaging findings. Written informed consent obtained after discussion of cramping, bleeding, infection, uterine perforation, vasovagal reaction, and the possibility of a non-diagnostic sample requiring repeat sampling or hysteroscopy. **Pregnancy excluded by negative urine hCG immediately before the procedure.** Chaperone (Marisol Vega, MA) present throughout. Ibuprofen 600 mg given orally 40 minutes prior; no paracervical block required.

Technique, specimens, findings

Patient in dorsal lithotomy. Sterile speculum placed, cervix and upper vagina prepped with povidone-iodine. Cervix grasped gently with a single-tooth tenaculum for stabilization — well tolerated. Uterus sounded to **10.5 cm** (enlarged, consistent with the fibroid uterus). A 3.1 mm Pipelle catheter was introduced to the fundus without resistance and four quadrants sampled with rotation and withdrawal under suction across two passes. An **adequate volume of tissue with abundant strips and fragments** was obtained and placed in formalin; specimen labeled and sent for histopathology. Tenaculum removed with minimal bleeding, controlled with pressure and silver nitrate to a single puncture point.

Tolerance, complications, aftercare, follow-up

Patient tolerated the procedure well with moderate cramping rated 5/10 during sampling, resolving to 2/10 within 10 minutes. **No complications** — no perforation (fundus reached at expected depth with no sudden loss of resistance), no vasovagal episode (vital signs stable throughout, monitored 15 minutes post-procedure), and minimal bleeding. Aftercare given in writing: expect spotting for 1–3 days and cramping for 24–48 hours; ibuprofen as needed; nothing per vagina and no intercourse for 48 hours; call for fever above 100.4 °F, foul discharge, bleeding heavier than a normal period, or severe pain. Pathology expected in 5–7 business days and will be communicated by telephone by the provider regardless of result, with a documented plan for what happens with each possible result.

ST SCREENING / ASSESSMENT TOOLS

9 STANDARDIZED TOOLS & INTERPRETATION

PHQ-9	**4 — minimal depressive symptoms. No prior score for comparison. Item 9 = 0.**
GAD-7	**3 — minimal anxiety. Situational concern about malignancy noted separately.**
Edinburgh Postnatal Depression Scale	**Not applicable — not pregnant or postpartum.**
Intimate partner violence screening	**HITS instrument, administered privately with the chaperone stepped out — score 4 of 20 (negative). Reproductive coercion screening also negative.**
Menopause symptom scale	**Menopause Rating Scale 9 — mild. Somatic subscale predominant (night sweats, sleep); urogenital subscale reflects dryness. Consistent with perimenopause, not sufficient to explain the bleeding.**
Menstrual bleeding diary	**Patient-completed pictorial blood loss assessment chart across three cycles: 210 (severe; over 100 defines menorrhagia). Documents 5–7 hours of hourly double-product saturation on peak days and intermenstrual bleeding in 4 of 5 cycles.**
Pelvic pain questionnaire	**Cyclic dysmenorrhea 6/10 days 1–2; non-cyclic pressure 3/10 daily, worse with prolonged standing. No dyspareunia-dominant or premenstrual-crescendo pattern.**
Sexual function questionnaire	**Not formally administered. Screening discussion documented dryness-related superficial discomfort and fatigue-related low libido, without avoidance of intimacy.**
Pregnancy risk screening	**Sexually active, ovulating, no method in use, pregnancy not desired — unmet contraceptive need identified and addressed.**
Substance use screening	**Never smoker. AUDIT-C 2 — negative. No drug use; single-question screen negative.**
Social determinants of health screening	**Negative across housing, food, transportation, utilities, and finances. No access barriers identified.**

L LABORATORY AND DIAGNOSTIC RESULTS

10 RESULTS REVIEWED OR ORDERED

Point-of-Care Testing (today)

Urine hCG negative — obtained immediately before biopsy. Urinalysis: clear, negative for leukocyte esterase, nitrites, and glucose; trace blood attributable to vaginal contamination; no signs of urinary tract infection. Wet mount: no trichomonads, no clue cells, no yeast, few white cells — normal. Point-of-care hemoglobin 10.4 g/dL, consistent with the venous result. Vaginal pH 5.0 (mildly elevated, consistent with atrophic change).

Gynecologic Testing

Endocervical gonorrhea and chlamydia nucleic acid amplification obtained today — pending, expected negative given the risk profile. HIV and syphilis serology ordered. Pap and HPV co-test 04/2024 negative and negative — next due 2029, not repeated today. No HSV testing indicated (no lesions).

Pregnancy Labs

Not applicable — not pregnant. Blood type A positive from 2014 delivery records, recorded for completeness. Rubella and varicella immune per 2014 prenatal labs.

Hormonal / Endocrine Labs

TSH 1.8 mIU/L with normal free T4 (08/12/2026) — thyroid disease excluded as a bleeding cause. Prolactin 12 ng/mL, normal. FSH 11.2 IU/L and estradiol 68 pg/mL on cycle day 3 — consistent with early perimenopause but not menopausal, and notably not an explanation for structural bleeding. HbA1c 5.4%. No androgen testing indicated (no hirsutism or virilization).

Hematology / Iron Studies

CBC 08/12/2026: hemoglobin 10.2 g/dL (was 12.9 in 2024), hematocrit 31.4%, MCV 76 fL, MCH 24 pg, RDW 17.2% — microcytic hypochromic anemia. Platelets 388,000 (reactive). WBC normal. **Ferritin 6 ng/mL**, transferrin saturation 8%, TIBC elevated — severe iron deficiency. Reticulocyte count 1.2%. Coagulation screen: PT, aPTT, and fibrinogen normal; **von Willebrand panel ordered** given lifelong menorrhagia and a 2014 postpartum hemorrhage — pending. B12 and folate normal. Vitamin D 24 ng/mL.

Imaging

Transvaginal and transabdominal pelvic ultrasound, 08/14/2026: Uterus enlarged at 12.8 × 8.1 × 7.4 cm. **Three fibroids identified** — (1) a 5.2 cm intramural fibroid of the posterior fundus with a submucosal component indenting the cavity, radiologically FIGO type 2–3; (2) a 3.8 cm intramural fibroid of the left lateral wall; (3) a 1.9 cm subserosal fibroid of the anterior fundus. **Endometrium 13 mm**, heterogeneous with an ill-defined interface adjacent to the type 2–3 fibroid — abnormal for a premenopausal cycle day 15 study and not reliably distinguishable from a polyp or hyperplasia. Both ovaries visualized and normal (right 2.8 cm, left 3.1 cm), no adnexal mass, no free fluid, no hydronephrosis on the limited renal views. Compared with the 2018 study (two fibroids, 2 and 3 cm), there is clear interval growth and a new lesion. **Saline infusion sonohysterogram and diagnostic hysteroscopy ordered** to characterize the cavity, since the fibroid distorts the endometrial assessment. Mammogram ordered (due).

Pathology

Endometrial biopsy obtained today — pending, expected in 5–7 business days. Adequate specimen volume documented at collection. No prior endometrial sampling for comparison. Pap cytology 04/2024 negative. No prior surgical pathology apart from the 2019 cholecystectomy specimen (chronic cholecystitis, benign).

Prior Records Reviewed

Primary care notes 2024–2026 including the 06/2026 CBC and ferritin and the iron prescription; 2018 pelvic ultrasound report documenting two fibroids of 2 and 3 cm (the key comparison study); 2014 delivery record documenting the 700 mL postpartum hemorrhage, blood type, and prenatal serologies; 2019 operative report and pathology from laparoscopic cholecystectomy; 04/2024 Pap and HPV co-test; 03/2025 mammogram report; pharmacy fill history confirming lisinopril adherence and intermittent iron fills; and the patient's own three-cycle bleeding log.

A ASSESSMENT

11 OB-GYN CLINICAL INTERPRETATION

- **Abnormal uterine bleeding — heavy menstrual bleeding with intermenstrual bleeding** in a 43-year-old, PBAC 210 (severe), with documented functional impairment. Classified as **AUB-L (leiomyoma)** with a submucosal component, with **AUB-M (malignancy or hyperplasia) not yet excluded** and biopsy pending. The perimenopausal transition (AUB-O) is a plausible contributor to cycle variability but cannot account for the volume, the clots, or the structural findings.

- **Uterine leiomyomata with interval growth.** Three fibroids on ultrasound — a 5.2 cm posterior fundal lesion with a cavity-indenting submucosal component (FIGO type 2–3), a 3.8 cm left lateral intramural, and a 1.9 cm subserosal — against two fibroids of 2 and 3 cm in 2018. The submucosal component is the single most likely driver of the heavy bleeding, as cavity-distorting fibroids increase endometrial surface area and impair contractile hemostasis. Uterine size corresponds to 14–16 weeks' gestation on examination and explains the pelvic pressure and urinary frequency through mass effect.
- **Thickened, heterogeneous endometrium at 13 mm with an ill-defined interface** — abnormal for this cycle day and not adequately characterized on ultrasound because of fibroid distortion. Polyp, hyperplasia, and malignancy all remain in the differential; saline sonohysterogram with hysteroscopy is required in addition to the biopsy, because a blind Pipelle sample can miss focal lesions in a distorted cavity.
- **Endometrial cancer risk is meaningfully elevated and drives the workup:** age 43 with intermenstrual bleeding, obesity (BMI 31.4, a well-established risk factor through unopposed peripheral estrogen), a first-degree relative with endometrial cancer at 58, a second-degree relative with colon cancer at 46, and a maternal grandmother with uterine cancer. **This family constellation meets criteria to evaluate for Lynch syndrome**, which would change her cancer surveillance, her colonoscopy timing, and potentially her surgical decision-making. Endometrial sampling was therefore performed today rather than deferred pending a trial of therapy.
- **Severe iron deficiency anemia secondary to menorrhagia** — hemoglobin 10.2 g/dL (from 12.9 in 2024), MCV 76, ferritin 6 ng/mL, transferrin saturation 8%, with pica, exertional dyspnea, palpitations, a flow murmur, and reactive thrombocytosis. Oral iron adherence is effectively about 50% because of gastrointestinal intolerance, so the current regimen will not repair a ferritin of 6 at the rate of ongoing loss. This requires its own targeted plan, not simply treatment of the bleeding.
- **Possible inherited bleeding disorder — under evaluation.** Lifelong heavy menses since menarche plus a 700 mL postpartum hemorrhage in 2014 satisfies screening criteria for von Willebrand disease; the panel is pending. A positive result would change management (favoring tranexamic acid and hematology co-management) and would matter for any future surgery. The normal skin examination without purpura or petechiae argues against a platelet-type disorder but does not exclude von Willebrand disease.
- **Differential considered and addressed:** endometrial polyp (likely and being sought on sonohysterogram); endometrial hyperplasia or carcinoma (biopsy pending, risk factors present); adenomyosis (possible — dysmenorrhea and a bulky uterus, though the discrete masses favor fibroids; MRI would clarify if surgery is planned); cervical pathology (excluded — smooth non-friable cervix, no contact bleeding, negative co-test 2024); coagulopathy (pending); thyroid disease and hyperprolactinemia (both excluded on labs); pregnancy and its complications (excluded, hCG negative); ovarian pathology (excluded — both ovaries normal, no adnexal mass); and infection or endometritis (no fever, no tenderness, no discharge, normal wet mount).
- **Unmet contraceptive need.** She is 43, ovulating, sexually active with no method, and does not desire pregnancy. Her prior copper IUD worsened bleeding, which specifically contraindicates repeating that device, whereas a levonorgestrel IUD would address contraception and bleeding simultaneously and provides endometrial protection — making it the single most efficient intervention if the cavity proves suitable.
- **Perimenopause** with mild vasomotor symptoms (Menopause Rating Scale 9) and mild genitourinary atrophy. Real, but explicitly not accepted as the explanation for her bleeding — a common and consequential diagnostic error at this age.
- **Preventive care gaps identified:** colon cancer screening never performed and now indicated ahead of the usual age given the family history; mammogram due; influenza and COVID-19 immunizations due. These were addressed at this visit rather than deferred.
- **No red flags requiring emergency care today** — hemodynamically stable, no orthostatic change, no active hemorrhage, no syncope, no fever, no acute pain, no ureteral obstruction on imaging. Management is urgent-outpatient: biopsy result, sonohysterogram with hysteroscopy, aggressive iron repletion, and immediate bleeding control while the diagnostic pathway completes.

P PLAN

12 MANAGEMENT BY PROBLEM

- **Bleeding control started today — treatment is not being withheld pending results.** Tranexamic acid 1,300 mg orally three times daily for up to 5 days beginning at the onset of heavy flow (contraindications reviewed and absent — no thrombosis history, no thrombophilia, no combined hormonal contraceptive in use). Scheduled ibuprofen 600 mg every 6 hours with food on days 1–3 of flow rather than PRN, which reduces blood loss as well as pain — the mechanism was explained. A written flow-day protocol was provided so she knows exactly what to take and when. She was counseled on why hormonal therapy is being sequenced after endometrial sampling.
- **Endometrial pathology — the pivot point.** Biopsy obtained today; result in 5–7 business days and communicated by telephone by me regardless of outcome, with a documented decision tree given to her in writing: if benign proliferative or secretory endometrium, proceed with the levonorgestrel IUD at the time of hysteroscopy; if hyperplasia without atypia, treat with progestin (levonorgestrel IUD preferred) with repeat sampling at 3–6 months; if **atypical hyperplasia or carcinoma**, urgent gynecologic oncology referral for staging and surgical management. She was told plainly that a benign result is the most likely outcome and that the biopsy was done because her risk profile makes certainty necessary.
- **Saline infusion sonohysterogram with diagnostic hysteroscopy ordered** within 2–3 weeks, scheduled in the follicular phase. Rationale explained: the 5.2 cm fibroid distorts the cavity, so a blind biopsy can miss a focal polyp or focal hyperplasia, and the 13 mm heterogeneous endometrium needs direct visualization. If a polyp or a FIGO type 1–2 submucosal fibroid is confirmed, **hysteroscopic polypectomy or myomectomy** is offered as a uterus-sparing, high-yield treatment for the heavy bleeding. Levonorgestrel IUD placement can be combined with the same procedure once pathology is benign.
- **Iron deficiency — escalated, not continued as is.** Oral ferrous sulfate is not achieving repletion at 50% adherence against ongoing loss with a ferritin of 6. Switching to **ferrous sulfate 325 mg every other day with 500 mg vitamin C**, taken away from tea, coffee, calcium, and her lisinopril — alternate-day dosing improves absorption and tolerance. **Intravenous iron (ferric carboxymaltose) ordered and scheduled** given ferritin 6, hemoglobin 10.2, symptomatic anemia, gastrointestinal intolerance, and continuing blood loss; this will correct her far faster than oral therapy and is the appropriate escalation. Repeat CBC and ferritin in 6 weeks, targeting ferritin above 50. Dietary counseling provided. No transfusion indicated — she is stable and not actively hemorrhaging.
- **Contraception and long-term bleeding management.** Full counseling delivered: levonorgestrel 52 mg IUD as first-line, giving over 99% contraceptive efficacy, an 80–90% expected reduction in menstrual blood loss, and endometrial protection — the single intervention that addresses the most problems at once. Copper IUD explicitly ruled out given her 2015–2018 experience of worsened bleeding. Combined hormonal contraception discussed as an alternative (she has no contraindication — non-smoker, no aura migraine, controlled BP), but the IUD is preferred at 43 with fibroids. Permanent options reviewed for both partners, including vasectomy, which her partner is considering. **Plan: place the levonorgestrel IUD at the time of hysteroscopy once benign pathology is confirmed**, under the same anesthesia, in a cavity already assessed and treated. Interim contraception: condoms, provided today, with clear instruction that no method is currently in place.
- **Fibroid management, sequenced.** Definitive options laid out with the patient: hysteroscopic myomectomy for the cavity-involving component (most likely to fix the bleeding, uterus-sparing); uterine artery embolization; abdominal or laparoscopic myomectomy; or hysterectomy, which she raised herself and toward which she is provisionally inclined given completed childbearing and her sister's experience. Pelvic MRI to be obtained if she proceeds toward myomectomy or embolization, for precise mapping and to assess for adenomyosis. Decision deliberately deferred until pathology and hysteroscopy return — and she was told that if Lynch syndrome is confirmed, hysterectomy with bilateral salpingo-oophorectomy would carry a risk-reduction rationale beyond symptom control, which could change her choice.
- **Genetic counseling referral placed — a priority of this visit.** Family history (mother with endometrial cancer at 58, maternal aunt with colon cancer at 46, maternal grandmother with uterine cancer) warrants evaluation for Lynch syndrome. Germline multigene panel testing will be arranged through genetics. If her endometrial biopsy shows carcinoma or hyperplasia, immunohistochemistry for mismatch repair proteins will be requested on the tissue. Cascade testing for her children and sister would follow a positive result. She understood the implications for her own surveillance and for her family and asked to proceed.

- **Colonoscopy referral placed.** Never screened, age 43, with a second-degree relative diagnosed with colon cancer at 46 and a first-degree relative with endometrial cancer — screening is indicated now, and would move to every 1–2 years starting in her twenties-to-thirties equivalent interval if Lynch syndrome is confirmed. Mammogram ordered (due since 03/2026). Influenza vaccination scheduled for the fall; COVID-19 booster offered and accepted.
- **Bleeding disorder evaluation.** Von Willebrand panel pending (von Willebrand factor antigen, activity, factor VIII, with ABO context). If abnormal, hematology referral and desmopressin planning before any surgery, with tranexamic acid becoming central to her regimen. Her 2014 postpartum hemorrhage and lifelong menorrhagia justify this; a negative result is reassuring for future operative planning either way.
- **Perimenopausal and genitourinary symptoms.** Vasomotor symptoms are mild and require no systemic therapy now; she was counseled that a levonorgestrel IUD does not treat hot flashes and that systemic menopausal hormone therapy can be revisited later, informed by whatever the endometrial pathology shows. For dryness: a vaginal moisturizer for regular use and a silicone-based lubricant for intercourse; low-dose vaginal estrogen offered and deliberately deferred pending endometrial pathology, with the rationale explained.
- **Blood pressure, weight, and general health.** Continue lisinopril 20 mg with good control; blood pressure documented today and no change made. Weight discussed in the specific context of endometrial risk — adipose-derived estrogen is a modifiable contributor — framed supportively and without moralizing; nutrition referral offered and accepted. Vitamin D3 increased to 2,000 IU daily for a level of 24. Alcohol intake within recommended limits; never-smoker status reinforced.
- **Coordination and patient education.** Coordination note sent today to Dr. Marsh summarizing the ultrasound findings, the biopsy, the intravenous iron plan, and the genetics and colonoscopy referrals. Referrals placed: genetics, gastroenterology, infusion center, nutrition, and radiology. Written after-care and a plain-language summary of the bleeding workup provided, with teach-back confirmed. **Instructed to go to the emergency department for** soaking more than two pads per hour for two consecutive hours, passing clots larger than a lemon with dizziness, fainting, chest pain, severe shortness of breath, or fever above 100.4 °F with pelvic pain; **and to call the clinic for** post-biopsy fever, foul discharge, worsening pain, or any question about the pathology result. Direct clinic and after-hours numbers given.

F FOLLOW-UP

13 REASSESSMENT PLAN

Follow-up

Telephone call within 5–7 business days with the endometrial biopsy result and the corresponding next step from the written decision tree. Saline infusion sonohysterogram with diagnostic hysteroscopy in 2–3 weeks (follicular phase), with hysteroscopic polypectomy or myomectomy and levonorgestrel IUD placement at that time if pathology is benign and the cavity is suitable. Intravenous iron infusion within 2 weeks; repeat CBC and ferritin at 6 weeks targeting ferritin above 50. Von Willebrand panel and STI, HIV, and syphilis results reviewed and communicated when available. Genetic counseling appointment within 4–6 weeks; colonoscopy within 8 weeks; mammogram within 4 weeks. Office follow-up in 8 weeks for bleeding-diary and PBAC reassessment, anemia recheck, contraception confirmation, and definitive fibroid decision-making. Sooner for any red-flag symptom as reviewed, or immediately if pathology shows atypia or carcinoma — in which case gynecologic oncology referral will be made the same day the result is received.

TB TIME DOCUMENTATION & BILLING

TOTAL TIME SPENT

64 minutes

COUNSELING / EDUCATION TIME

22 minutes — bleeding workup, cancer risk, fibroid options, iron plan

CONTRACEPTION COUNSELING TIME

11 minutes — levonorgestrel IUD, permanent options, interim method

PRENATAL / POSTPARTUM COUNSELING TIME

Not applicable

PROCEDURE TIME

14 minutes — endometrial biopsy including consent and post-procedure observation

CARE COORDINATION TIME

7 minutes — genetics, gastroenterology, infusion, nutrition referrals

RECORDS REVIEW TIME

10 minutes — 2018 ultrasound comparison, 2014 delivery record, primary care labs

E/M LEVEL

99215 — established patient, high-complexity MDM (64 minutes; malignancy risk, escalation to IV iron, multi-specialty coordination)

PREVENTIVE VISIT CODE

Not billed — problem-focused visit; preventive items addressed and documented

PRENATAL / GLOBAL OB CODE(S)

Not applicable

PROCEDURE CODE(S)

58100 — endometrial biopsy without cervical dilation (modifier 25 on the E/M). Planned: 58558 hysteroscopy with polypectomy or myomectomy; 58300 IUD insertion; 76831 saline infusion sonohysterogram

SCREENING CODE(S)

87491 / 87591 — chlamydia and gonorrhea NAAT; 86703 HIV; 86592 syphilis; Z12.31 mammogram screening; Z12.11 colon cancer screening

CONTRACEPTIVE MANAGEMENT CODE(S)

Z30.09 — encounter for other general counseling and advice on contraception

BASIS FOR BILLING

Time-based and high-complexity MDM plus a separately identifiable procedure (endometrial biopsy) on the same date

PRIMARY DIAGNOSIS

N92.0 — Excessive and frequent menstruation with regular cycle, with N93.8 other specified abnormal uterine and vaginal bleeding (intermenstrual)

SECONDARY DIAGNOSES

D25.1 Intramural leiomyoma of uterus; D25.0 Submucous leiomyoma of uterus; N85.00 Endometrial hyperplasia, unspecified (suspected, pending pathology); D50.0 Iron deficiency anemia secondary to blood loss; Z80.49 Family history of malignant neoplasm of other genital organs; Z80.0 Family history of malignant neoplasm of digestive organs; E66.9 Obesity; N95.1 Menopausal and perimenopausal state; Z30.09 Contraceptive counseling; I10 Essential hypertension

SO PROVIDER SIGN-OFF

PROVIDER NAME	CREDENTIALS	SPECIALTY	DATE	TIME
Serena L. Whitcomb, MD	MD, FACOG	Obstetrics & Gynecology	08/19/2026	16:48

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