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The Editor's Workshop

Pediatric and adolescent gynecology is rapidly evolving as an independent entity in the expanding spectrum of health care. Interaction among pediatricians, obstetricians/gynecologists, psychiatrists, family practitioners, and allied health professionals is critical to ensure that these young patients receive the best health care we can provide.

Increased interest and enthusiasm for the specialty of pediatric and adolescent gynecology has been manifested in many ways. One such display was the second annual meeting of the North American Society for Pediatric and Adolescent Gynecology (NASPAG) held in Cleveland. This meeting served as a unique forum for the transfer of knowledge and research from many institutions. I will mention only a few of the many outstanding communications.

Areas of health care as basic as the physical examination of a pediatric gynecologic patient took on new fervor. Dr. Trina M. Anglin of Cleveland Metropolitan General Hospital detailed an excellent method for examination of a young child whereby the mother reclines or sits on the examining table in the dorsal lithotomy position with the young patient placed over her abdomen or between her thighs. Another topic of increasing importance is proper knowledge of what is a "normal" appearance of the hymenal-introital orifice during the physical exam. This information was detailed by Dr. Susan F. Pokorny of the Baylor Medical Center and is now presented in the lead article in our Original Studies section of this issue. A third point of interest is that of the role of colposcopy, especially when evaluating the sexually abused child. Although a controversy exists as to the use of colposcopy, Dr. David Muram of the University of Tennessee at Memphis discussed this technique as a means of photodocumentation of any trauma at the time of initial examination. However, he concludes that since experience in general is limited in this type of management, the clinician should interpret findings "with caution."

Our method of treating precocious puberty has undergone significant re-evaluation and enhanced understanding in recent years. We have always been able to intercede and effectively eliminate the progression of true idiopathic precocious puberty, but the challenge has been how to impede acceleration of bone age. With the use of GnRH analogues, we can now achieve such a goal. This important development was addressed by Drs. Sanging Shu and Geoffrey P. Redmond of The Cleveland Clinic Foundation. They emphasized that, because we can impede acceleration of bone age, we must be more cognizant in assessing adolescent growth patterns so as not to overlook situations in which adult height will be impaired if we do not intervene. Examples were given of children with hypothalamic lesions whose pubertal growth concealed an underlying growth deficiency. As clinicians, we must continue to look to new analogues as they are introduced in the "armamentarium" of

available medications for treatment of this endocrinological aberration.

As we approach new horizons in pediatric gynecology, it becomes even more important to realize that increased understanding of molecular biology as applied to the subspecialty provides us with clinically applicable information. DNA probes aid in unraveling the endocrinological disturbances in chromosomally competent ovarian failure. This topic was addressed by Dr. Richard H. Reindollar of The New England Medical Center. Increasing roles for these DNA probes in the diagnosis of congenital adrenal hyperplasia was covered in our last issue.

A basic problem we often must evaluate in young patients is pelvic pain. According to Dr. Alvin F. Goldfarb, President of NASPAG, we must realize that adolescents with this complaint may be suffering from "irritable bowel syndrome." Pelvic pain may be caused also by poor eating habits that lead to abnormal bowel function. Therefore, the importance of obtaining a detailed nutrition history is mandatory in the evaluation of pelvic pain in this age group.

"Is she naturally thin, or does she have an eating disorder?" This interesting query was addressed by Dr. Mark Strickland, a psychiatrist at The Cleveland Clinic Foundation, who specializes in adolescent care. He stressed that the patient with bulimia is not always thin. An interesting observation was that bulimia is four to five times as common as the better known disorder anorexia nervosa. Behaviors such as "binge" eating or lack of control over eating habits are hallmarks for this diagnosis.

Have you ever been faced with an insistent parent who has brought her teenage daughter to you for prevention of excessive height? Constitutional tall stature is a multifaceted problem with psychological as well as social aspects. Is there treatment for this complicated problem? The answer is ethinyl estradiol, 0.1–0.15 mg daily with the addition of a progestin during the last 13 days of the cycle. Monitoring the effect of the estrogen therapy on somatomedins is a useful means of determining efficacy of treatment regimens.

What are we doing about teenage pregnancy? The American College of Obstetricians and Gynecologists along with the American Academy of Pediatrics is actively working on this large-scale problem with hopes of discovering new means of combating this teenage dilemma. Dr. Robert T. Brown in Columbus, Ohio, in addressing this subject, tells us that perhaps the key lies in the establishment of a nonthreatening, accessible clinical environment. He also stressed the importance of a good doctor/patient relationship. Recommendations include good health habits, sound nutrition, and appropriate counseling. Importantly, the ability to assess substance abuse and deal with it is crucial in completing the health care picture for the pregnant teenager.

Reproductive problems of adolescent girls cured of childhood malignancies is an ever-expanding area of interest. Children with Hodgkin's disease have a 10-year survival rate of 90% according to Dr. David Muram. It has become increasingly important to consider procedures such as ovariopexy to remove ovaries from the immediate area of radiation exposure. In addition, those cured of malignancy but without functional ovarian tissue may well be candidates for embryo transfer.

I wish I had the opportunity to expound further on the many other interesting and exciting areas addressed at the NASPAG meeting, but time and space prevent me from continuing. However, we are devoting this issue to communicating some of the information from the NASPAG meeting. I hope this issue and future ones as well may serve to further encourage the enthusiasm already generated and to consolidate and enhance a well-rounded health care delivery system for the pediatric and adolescent gynecologic patient.

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