Received: 15 March 2024 | Accepted: 2 April 2024

DOI: 10.1111/jog.15950

GUIDELINES

Guideline for gynecological practice in Japan: Japan Society of Obstetrics and Gynecology and Japan Association of Obstetricians and Gynecologists 2023 edition

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Abstract

Twelve years after the first edition of The Guideline for Gynecological Practice, which was jointly edited by The Japan Society of Obstetrics and Gynecology and The Japan Association of Obstetricians and Gynecologists, the 5th Revised Edition was published in 2023. The 2023 Guidelines includes 5 additional clinical questions (CQs), which brings the total to 103 CQ (12 on infectious disease, 30 on oncology and benign tumors, 29 on endocrinology and infertility and 32 on healthcare for women). Currently, a consensus has been reached on the Guidelines, and therefore, the objective of this report is to present the general policies regarding diagnostic and treatment methods used in standard gynecological outpatient care that are considered appropriate. At the end of each answer, the corresponding Recommendation Level (A, B, C) is indicated.

KEYWORDS

gynecologic oncology, gynecology, infections, menopause and women's health, reproductive endocrinology and infertility

INTRODUCTION

The Guideline for Gynecological Practice 2023 is the fifth edition. It is the product of revisions that were included every 3 years since the publication of the first edition in 2011. The 2023 Guideline was jointly edited and published by The Japan Society of Obstetrics and Gynecology and The Japan Association of Obstetricians and Gynecologists. Literature searches were conducted using PubMed and the *Journal of Health Care and Society*. The guideline was created for obstetricians and gynecologists. The Guidelines are intended for use by physicians

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routinely involved in gynecological outpatient care. Our fundamental policy regarding its creation was to review papers published in Japan and overseas through April 2022, and to identify and recommend testing procedures and treatment methods that more than 80% of the committee members considered to be practically feasible in Japan and to have benefits that greatly outweigh any potential risks known at the time of publication. The 2023 edition contains 103 clinical questions (CQs). These include five new CQ that were added. In addition to CQs and answers, the original edition of the Guideline for Gynecological Practice in Japan 2023 also contained key words, descriptions of implications, and a reference section. These have all been omitted from this report due to space limitations. The difference between the 2020 and 2023 editions is that 12 items (12%) have had their titles changed, and 70 items (71%) have had their answers changed.

IMPLICATIONS OF "A," "B," AND "C" RECOMMENDATION LEVELS

The recommendation levels are the result of comprehensive consideration of factors such as clinical effectiveness, evidence, prevalence, and medical economics and have been determined based on a consensus of at least 80% of the committee that prepared these guidelines. Recommendation levels are not necessarily based on evidence level. Their implications are as follows: level A indicates that implementation is strongly recommended, level B indicates that implementation is recommended, and level C indicates that implementation or other action is to be considered. Some answers contain recommended tests and/or treatments that may be difficult for some facilities to provide. In such cases, it is to be understood that the guidelines imply that gynecologists are to "consult with facilities that are able to provide the services and refer and transfer patients to such facilities." A specific example of such a case would be "In cases in which your own medical facility is incapable of providing a treatment, consultation with and referral to a facility that is capable of providing the treatment is A: strongly recommended, B: recommended, C: should be considered."

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Chapter A. Infectious disease (CQ101–CQ112).
Chapter B. Oncology and benign tumors (CQ201–CQ230).
Chapter C. Endocrinology and Infertility (CQ301–CQ329).
Chapter D. Healthcare for women (CQ401–CQ432).

INFECTIOUS DISEASE

CQ101 How do we diagnose and treat chlamydia cervicitis?

Answer

1. Diagnosis uses nucleic acid amplification methods (e.g., polymerase chain reaction, strand displacement assay and transcription-mediated amplification, etc.) to detect chlamydia from cervical scraping specimens. (A)
2. A simultaneous test for *Neisseria gonorrhoeae* is performed using the nucleic acid amplification method. (B)
3. Treat with oral macrolide or quinolone antibiotics. (A)
4. Degree of recovery should be determined at least 3 weeks after treatment. (B)
5. Recommend testing and treatment to the patient's partner. (B)

CQ102 How do we diagnose and treat gonorrhea infection?

Answer

1. To diagnose genital infections, pathogens are detected from cervical scrape specimens using nucleic acid amplification or isolation culture methods. (A)
2. If pharyngeal infection is suspected, a pharyngeal specimen should be collected and tested as described above. (B)
3. Simultaneous testing for chlamydia should be performed using nucleic acid amplification. (B)
4. The first choice of treatment is a single dose of intravenous ceftriaxone or intramuscular spectinomycin. (B)
5. Since resistant bacteria exist, monitor the effectiveness of treatment appropriately. (B)
6. Recommend testing and treatment to the patient's partner. (B)
7. Genital gonococcal infections occurring in children should be considered sexual abuse (see CQ431). (B)

CQ103 How do we diagnose and treat genital herpes?

Answer

1. Perform pathogenic diagnosis using specimens from lesions, or perform clinical diagnosis based on medical history, clinical symptoms and local findings. (B)
2. Detection of viral antigens (fluorescent antibody method, immunochromatography) or cytological

diagnosis are used to confirm the diagnosis. If the specimen collection from lesions is difficult, serological diagnosis based on IgM/IgG antibody titer measurement by enzyme-linked immunosorbent assay can be used. However, since there are four clinical types of genital herpes; primary infection/initial symptom onset, recurrent infection/initial symptom onset, recurrent onset, or asymptomatic infection, diagnosis based on serological tests should be done carefully. (B)
3. Treatment includes administration of acyclovir, valacyclovir, and famciclovir. (A)
4. For patients with recurrent clinical episodes (more than six times a year or severe symptom) of genital herpes simplex virus infection, the use of valaciclovir is suggested to suppress recurrence. (B)

CQ104 How do we diagnose and treat genital warts?

Answer

1. Clinical symptoms and presentation are usually sufficient for diagnosis. Biopsy and pathological evaluation can be performed when necessary. (B)
2. Treat with imiquimod 5% cream. (B)
3. Surgical options to remove genital warts include excision, cryotherapy, electrocautery, and laser vaporization. (C)

CQ105 How do we diagnose and treat syphilis?

Answer

1. The diagnosis is confirmed by syphilis antibody testing (non-treponemal lipid antibody test and treponemal pallidum antibody test) or detection of the pathogen, and the stage is determined. (A)
2. For treatment, penicillin is used unless there is an event, such as an allergy. For early syphilis, treatment options include a 4-week course of oral penicillin (AMPC, ABPA) or a single dose of long-acting intramuscular benzylpenicillin. (A)
3. Healing is determined by rapid plasma reagin. (A)
4. If the diagnosis of syphilis is confirmed, the physician who made the diagnosis should submit a notification in accordance with the Infectious Diseases Control Law. (A)
5. If syphilis is diagnosed, a human immunodeficiency viruses (HIV) test should be performed after sufficient explanation. (B)
6. If neurological symptoms are present, neurosyphilis is suspected. (B)

CQ106 How do we diagnose and treat vaginal trichomoniasis?

Answer

1. *Trichomonas vaginalis* is confirmed by microscopic examination of vaginal secretions. (B)
2. If protozoa cannot be confirmed by microscopic examination, culture should be performed. (C)
3. Treatment is generally systemic administration of oral drugs, such as metronidazole or tinidazole. (A)
4. Encourage the patient's partner to receive the same treatment (orally administered) at the same time. (B)

CQ107 How do we diagnose and treat Candida vulvovaginitis?

Answer

1. The presence of Candida is confirmed by direct microscopic examination of the vulva and vagina, or by culture, and the diagnosis is made in conjunction with clinical symptoms. (B)
2. Treatment consists of topical or oral antifungal drugs. Use cream or ointment on the vulva. (A)
3. The patient is considered treated when the subjective symptoms disappear and the leukorrhea findings improve after treatment. (A)

CQ108 How do we diagnose and treat bacterial vaginosis?

Answer

1. Objectively diagnose by Nugent score using Gram-stained specimen of leukorrhea or diagnose using Lactobacillary grade using saline specimen of leukorrhea. (C)
2. Treatment includes topical or oral metronidazole therapy. (A)

CQ109 How do we diagnose PID?

Answer

Pelvic inflammatory disease (PID) should be considered in the differential diagnosis and examined based on the following criteria. (B)

[Medical interview]

1. Degree, nature, and course of symptoms.
2. Sexual activity, recent intrauterine manipulation, and likelihood of pregnancy.
3. History of underlying gynecological diseases, such as endometriosis or sexually transmitted diseases.

[Essential diagnostic criteria]

1. Lower abdominal pain, lower abdominal tenderness.
2. Uterus and appendage tenderness.

[Additional diagnostic criteria and specific diagnostic criteria]

1. Body temperature ≥38.0°C
2. Leukocytosis.
3. Elevated c-reactive protein.
4. Abscess image confirmation by transvaginal ultrasound or magnetic resonance imaging (MRI).
5. Identification by culture or antigen testing of the causative microorganism, or genetic diagnosis.

CQ110 How do we treat PID?

Answer

1. In principle, outpatient treatment is required, but hospitalization is indicated in the following cases. (B)
   - Patients who cannot exclude surgical emergencies (such as appendicitis).
   - Pregnant women.
   - Patients in whom oral antibiotics were ineffective.
   - Patients who cannot receive oral antibiotics.
   - Patients with nausea/vomiting and high fever.
   - Patients with tubo-ovarian abscess.
2. In initial treatment when the causative bacteria have not been identified, the causative bacteria are estimated based on interviews, examinations, and laboratory findings for each patient, and appropriate antibiotics are considered. (B)
3. If the involvement of chlamydia cannot be ruled out, select a new quinolone or azithromycin. (B)
4. If the causative bacterium is identified, change the optimal treatment accordingly. (B)
5. If anaerobic bacteria is suspected, metronidazole can be used in combination. (C)

CQ111 How do we diagnose and treat urinary tract infections?

Answer

1. Urinary tract infections are diagnosed based on subjective symptoms related to urination, pyuria, and bacteriuria, and are classified based on clinical course, presence or absence of underlying disease, and site of infection. (A) A urine culture is recommended. (B)
2. For the initial treatment of acute uncomplicated cystitis, antibiotics should be selected by considering the tendency of the causative bacteria before and after menopause, and quinolones and cephems are recommended before menopause. (B)
3. After menopause, penicillin and cephem antibiotics combined with β-lactamase inhibitors are recommended. (B) Cephem or penicillin antibiotics are recommended for pregnant women (or women who may become pregnant). (B)
4. If no improvement is observed, antibiotics should be reconsidered based on the results of urine culture and susceptibility tests. (B)
5. For the initial treatment of acute uncomplicated pyelonephritis, β-lactam drugs and quinolone antibiotics are recommended if the disease is mild. (A) Antibiotics should be reconsidered based on the results of urine culture and susceptibility tests. (B) Depending on the degree of fever and dehydration, consider referring the patient to a specialized medical facility. (B)

CQ112 What about sexually transmitted disease screening (set tests)?

Answer

1. Tests are conducted for four diseases: genital chlamydia infection, gonorrhea infection (cervical secretions and scrapings), syphilis, and HIV infection (blood). (B)
2. For high-risk patients, additional tests for vaginal trichomoniasis (vaginal secretions) and hepatitis B and C (blood) are performed. (B)
3. For chlamydia and gonorrhea, a throat test is also performed if there is a risk of throat infection. (C)

ONCOLOGY AND BENIGN DISEASE

CQ201 What is the appropriate method for performing cervical cytology?

Answer

1. Cells are collected mainly from the squamocolumnar junction area of the cervix. (B)
2. For non-pregnant women, cells should be collected using a spatula or brush (including bloom type) instead of a cotton swab. (B)
3. The liquid-based cytology method is used for specimen preparation. (B)

CQ202 What is the case for colposcopy/biopsy as a detailed examination after cervical cytology?

Answer

1. When cervical cytology results indicate low-grade squamous intraepithelial lesion, atypical squamous cells (ASC-H), high-grade squamous intraepithelial

lesion, squamous cell carcinoma, atypical glandular cells, adenocarcinoma in situ, adenocarcinoma, or other malignant neoplasms, a biopsy should be performed immediately. (B)
2. If the cervical cytology result is ASC-US, perform it in the following cases.
   - Result of high-risk human papillomavirus (HPV) test* is positive. (B)
   - At facilities where high-risk HPV testing is not available, perform if cytology retests after 6 and 12 months are ASC-US or higher (B), or perform immediately. (C)
3. If the cervical cytology result is negative but an HPV test has been performed, the following circumstances apply
   - Perform when the patient is judged to be a persistently high-risk HPV-positive. (C)
   - Performed when the patient is positive for HPV type 16 or 18. (C)

*To carry out high-risk HPV testing as medical treatment covered by health insurance, certain facility standards must be met, and this only applies if the cytology result is ASC-US or if the test is performed after cervical conization.

CQ203 In what cases should high-risk HPV testing be used?

Answer

1. Used to determine the need for colposcopy/biopsy when cytology result is ASC-US. (B)
2. It is used for early detection of residual lesions and recurrence in the management of cases after conization for CIN2/3. (B)
3. Used as one option of the testing methods for cancer screening*. (B)

*Currently, cervical cytology is to be adopted for preventive cancer screening, in accordance with notification from the Director-General of the Health Bureau of the Ministry of Health, Labor and Welfare. Hence, currently, only some regions (11.4%) are performing combined cytology/HPV testing; however, HPV testing alone has not yet been performed.

CQ204 What is the management/treatment for CIN1/2 confirmed by histological diagnosis?

Answer

1. CIN1 should be followed up every 6 months with cytology and colposcopy if necessary. (B)
2. Patients with CIN2 should be closely monitored every 3 to 6 months using a combination of cytology and colposcopy. (B)
3. When performing an HPV typing test to assess the risk of progression to CIN1/2, lesions positive for HPV types 16, 18, 31, 33, 35, 45, 52, and 58 have a high risk of progression. Therefore, these should be managed separately from other HPV-positive or HPV-negative cases. (B)
4. CIN2 can be treated in the following cases, except in pregnant women: (B)
   - If the disease does not disappear spontaneously during the 1–2 year follow-up period
   - Positive for HPV types 16, 18, 31, 33, 35, 45, 52, or 58.
   - When the patient has a strong desire for such treatment.
   - If it is difficult to receive regular medical examinations.

CQ205 LEEP as a minimally invasive alternative to cervical conization, when is laser ablation performed?

Answer

LEEP as a diagnosis and treatment

1. Performed when cervical intraepithelial neoplasia grade 3 (CIN3) is confirmed by histology, the entire extent of the lesion can be confirmed by colposcopy, and the lesion does not extend deep into the cervical canal. (B)
2. CIN2 confirmed by histology can be treated (in accordance with CQ204 Answer 4) if the full extent of the lesion is visible by colposcopy and the lesion does not extend deep into the cervical canal: (B)

Laser ablation as a treatment

3. Laser ablation treatment can be performed only in young women with CIN3 confirmed by multiple histological examinations, the full extent of the lesion clearly visible on colposcopy, and when there are no intracervical lesions. (B)
4. For CIN2 confirmed by multiple histological examinations, if the entire extent of the lesion is clearly seen by colposcopy and there is no intracervical involvement, treatment is recommended (according to CQ204 Answer 4) only in young women. (B)

CIN2 can be treated in the following cases, except in pregnant women:

- If it does not disappear spontaneously after 1 to 2 years of follow-up.
- Positive for HPV types 16, 18, 31, 33, 35, 45, 52, or 58.

- When the patient is strongly against such treatment.
- If it is difficult to receive regular medical examinations.

CQ206 How should polypoid lesions in the cervix be handled?

Answer

1. In principle, the tumor is excised and a histological examination is performed. (B)
2. If there are no symptoms, the possibility of a malignant lesion can be ruled out, and no histological examination is performed, the patient's progress should be observed. (B)
3. If pregnant women are suspected of having cervical dilatation or chorioamnionitis, excision and antibiotics should be administered as necessary. (C)
4. Depending on the size and shape, the resection method is selected from among the following: (1) evulsion using Pean forceps, (2) ligation/excision, and (3) cauterization using an electric scalpel or laser scalpel. (B)

CQ207 Who should receive HPV vaccine?

Answer

1. Girls aged 10–14 years of age are in the most highly recommended group. (A)
2. The next highest recommended group is girls and women aged 15–26 years of age. (A)
3. Women aged 27–45 years of age may receive the vaccine upon request. (B)
4. Women who have current evidence or history of low-grade cervical abnormalities may receive the vaccine. (B)
5. HPV testing should not be used to decide whether a woman is eligible for the vaccine. (B)
6. Pregnant women should not be vaccinated. (B)

CQ208 What are the instructions for HPV vaccination?

Answer

Include the following:

1. Both the 2-valent vaccine (Cervarix®) and the 4-valent vaccine (Gardasil®) protect against HPV16/18 infection. The vaccine can be expected to provide a 60%–70% protection against cervical cancer when administered to girls and women who are not yet sexually active. (A)
2. The 9-valent vaccine (Silgard®9) protects against HPV types 16, 18, 31, 33, 45, 52, and 58 infection. This vaccine can be expected to prevent approximately 90% of cervical cancers when administered to women who have never had sexual intercourse. (B)
3. Both the quadrivalent vaccine (Gardasil®) and nine-valent vaccine (Silgard®9) prevent HPV types 6 and 11 infection, in addition to the HPV types mentioned above, and are also effective in preventing genital warts. (A)
4. It is not effective on pre-existing cervical cancer, precancerous lesions, or pre-existing HPV infection. (B)
5. The vaccination is most effective when administered to sexually naive women. (B)
6. Vaccinated women should undergo routine cervical cancer screening. (B)
7. Review vaccination schedule and cost. (A)
8. Mention the possibility of major adverse events, such as local pain, redness, swelling, headache, syncope, and shock. (A)
9. Discuss immunization stress-related response. (B)
10. Vaccinated girls and women who experience abnormal reactions such as pain, numbness or weakness that is not limited to the injection site should, either directly or through their parent or guardian, inform their regular physician or the physician who performed the vaccination and immediately undergo a medical examination. (A)

CQ209 How should the HPV vaccine be administered?

Answer

1. Confirm the suitability of vaccination by interview, temperature measurement and physical examination before vaccination. (A)
2. Shake the vaccine syringe thoroughly before inoculating. A frozen vaccine should never be used. (A)
3. Cervarix® is injected intramuscularly into the deltoid muscle of the upper arm at 0, 1, and 6 months, and Gardasil® and Silgard®9 are injected at 0, 2, and 6 months. For Silgard®9, if the first vaccination is administered by the day before the 15th birthday, a total of two vaccinations can be administered with an interval of 6 to 12 months (0, 6 to 12 months). (B)
4. As a general rule, complete the vaccination schedule with the same type of HPV vaccine. (A)
5. Those who have received a COVID-19 vaccine should be vaccinated with at least 14 days gap between vaccinations. (A)
6. Serious adverse events, such as fainting, anaphylactic shock, and convulsions, may occur, so it is recommended to wait 30 min after vaccination, and special care must be taken during the first 15 min. (A)

CQ210 What are the appropriate collection methods and test subjects for endometrial cytology?

Answer

1. Endometrial cell sampling is performed by scraping or aspiration. (B)
2. Selectively targeting women with symptoms suggesting the presence of endometrial cancer or those with risk factors. (C)

CQ211 How do we diagnose and treat endometrial hyperplasia without atypia?

Answer

1. If abnormal endometrial cytology or endometrial hyperplasia is detected, a definitive diagnosis is made by endometrial biopsy. If lesions of endometrial atypical hyperplasia or higher are suspected, the diagnosis should be made by full surface curettage of the endometrium. (A)
2. If treatment is required, administer medroxyprogesterone acetate periodically. (B)
3. Levonorgestrel-releasing intrauterine systems are used for endometrial hyperplasia associated with menorrhagia. (C)
4. Estrogen/progestin combination drugs are administered during the period of sexual maturity. (C)
5. If the patient wishes to have a baby after receiving the treatments outlined in Answers 2 to 4, perform infertility treatment, including ovulation induction. (C)
6. Total hysterectomy may also be considered if fertility preservation is not required. (C)

CQ212 What are the methods of diagnosis and management of endometrial polyps?

Answer

1. Perform transvaginal ultrasound tomography as a primary examination. (A)
2. Perform an endometrial test to rule out malignancy. (B)
3. Diagnose using sonohysterography or hysteroscopy. (B)
4. For definitive diagnosis and treatment, hysteroscopic surgery or endometrial curettage should be performed in the following cases. (B)
   - Patients with symptoms.
   - Patients with infertility in which endometrial polyps are thought to be a factor in infertility.
   - Possibly malignant cases, even if asymptomatic.
5. For cases other than Answer 4, follow up. (B)

CQ213 In what cases (diseases) is hysteroscopy performed?

Answer

Hysteroscopy is used in cases, such as irregular bleeding, suspicion of malignant tumor, a detailed examination of infertility, and suspicion of uterine malformation. Specifically, it is used for the diagnosis and examination of the following diseases.

1. 1.Performed for diagnosis of the following diseases: (C)

   Endometrial polyp.
   Uterine submucosal fibroids.
   Congenital uterine malformation.
   Uterine adhesion (Asherman's Syndrome).
   Endometrial hyperplasia.
   Uterine cancer.
   Remnants after miscarriage or molar delivery.
   Retained placenta, placental polyp.
   Intrauterine foreign body (IUD).

2. Performed as a preoperative test for hysteroscopic surgery. (B)

   Endometrial polyp.
   Uterine submucosal fibroids.
   Septate uterus.
   Uterine adhesion (Asherman's Syndrome).

CQ214 When should hysteroscopic myomectomy be performed?

Answer

Ideal conditions include a uterine fibroid with a diameter of 30 mm or less and a degree of protrusion of 50% or more into the uterine cavity; however, this is not the case for particularly skilled surgeons. (B)

CQ215 How should uterine fibroids be treated when fertility preservation is not desired/needed?

Excluding cases that can be treated with hysteroscopic or vaginal myomectomy alone

Answer

1. If the disease is asymptomatic and the fibroids are not large, follow up regularly. (B)
2. If the patient has symptoms, such as excessive menstruation, dysmenorrhea, or pressure symptoms, a hysterectomy is generally performed. (B)
3. Perform uterine artery embolization (UAE) as an alternative treatment to surgery. (C)

4. To improve excessive menstruation, endometrial ablation, levonorgestrel-releasing intrauterine system (LNG-IUS), estrogen/progestin combination drugs, and tranexamic acid are used. (C)
5. In the premenopausal age group, gonadotropin hormone-releasing hormone (GnRH)agonist therapy or GnRH antagonist therapy is performed. (C)

CQ216 How should uterine fibroids be treated when fertility preservation is desired/needed?

Excluding cases that can be treated with hysteroscopic or vaginal myomectomy alone

Answer

1. If the patient has symptoms, such as excessive menstruation, dysmenorrhea, pressure symptoms, or infertility, or if the major axis exceeds 5–6 cm, consider the location, size, number, and growth rate of the uterine fibroids, and timing of pregnancy and childbirth to determine whether or not enucleation is necessary. (B)
2. Patients with asymptomatic lesions within 5–6 cm in length should be followed up regularly. However, large numbers of the uterine fibroids are handled in the same manner as those with a major axis exceeding 5–6 cm. (B)
3. Enucleation can be performed during other gynecologic procedures, even if the tumor is asymptomatic and has a major axis of up to 5–6 cm. (C)
4. Enucleation is performed when there is a disorder due to uterine fibroids during the previous pregnancy/delivery. (C)

CQ217 How do we diagnose and treat adenomyosis?

Answer

1. Diagnosis is based on symptoms, pelvic examination, and ultrasonography, but an MRI examination is performed when differentiation from uterine fibroids or uterine sarcoma is required. (B)
2. Symptomatic treatment and hormone therapy similar to those for endometriosis should be performed (see CQ222). (C)
3. Hysterectomy is performed as a radical therapy. (B)

CQ218 What should be considered when performing microwave endometrial ablation?

Answer

1. It is used as an alternative treatment when conservative treatment (drug therapy) is ineffective and hysterectomy is being considered to control excessive menstruation. (B)
2. This is performed when the following conditions are satisfied.
   - For women who do not wish to preserve fertility. (A)
   - To exclude endometrial malignancies; (B)
   - At least 1 cm of myometrium is secured. (A)
   - The entire uterine cavity can be reached by the microwave applicator. (A)

CQ219 How do we diagnose and manage ovarian cysts, which are considered benign tumors?

Answer

1. Differentiate malignant tumors, non-neoplastic lesions, and functional cysts using medical history, internal examination, ultrasonography, MRI, tumor markers, etc. (B)
2. If the cyst is large (greater than 5 cm in the major axis), surgery is recommended depending on the severity of symptoms. (B)
3. Even if the cyst is small, surgery is recommended if the tumor can be definitively diagnosed. (C)
4. If surgery is not selected, follow-up should be performed initially after 1–3 months considering the menstrual cycle, and subsequently every 3–6 months. (C)
5. Explain the limitations of clinical diagnostic accuracy without surgery. (A)

CQ220 How do we diagnose hemorrhagic luteal cyst/ovarian bleeding?

Answer

1. A comprehensive diagnosis is made based on interviews, basal body temperature (BBT), abdominal findings, ultrasound findings, etc. (B)
2. If intra-abdominal bleeding is observed, exclude ectopic pregnancy. (B)
3. If massive intra-abdominal bleeding is suspected accompanied by poor vital signs, or if hemoglobin levels drop rapidly because of continuous bleeding, emergent surgery should be performed. (B)

CQ221 How do we diagnose and treat ovarian endometriotic cysts (chocolate cysts)?

Answer

1. Observation, drug therapy, or surgical therapy should be selected by considering age, size of cyst, degree of pain, and desire to have children. Surgical treatment

is given priority when pathological diagnosis is considered necessary. (B)
2. When conducting surgical therapy, the surgical method is determined by considering radical treatment and the need to preserve ovarian function. (B)
3. The frequency of malignant transformation and clinical characteristics are fully explained based on age, cyst size, and the presence or absence of solid areas. (B)
4. For patients who do not wish to become pregnant immediately after conservative surgery, hormone therapy is performed to prevent recurrence. (B)

CQ222 How do we treat endometriosis without cystic lesions?

Answer

1. For pain, first treat symptomatically with analgesics non-steroidal anti-inflammatory drugs (NSAIDs). (B)
2. If analgesics are insufficiently effective or if treatment for endometriosis itself is required, low-dose estrogen/progestin combination drugs or progestin are administered as the first choice, and GnRH analogs or danazol are administered as the second choice. (B)
3. Levonorgestrel-releasing intrauterine systems are used when analgesics are insufficiently effective. (B)
4. If drug therapy is ineffective or infertility occurs, surgery is performed to cauterize and remove the endometriosis lesion and release the adhesions. (B)

CQ223 How to handle Bartholin gland cysts?

Answer

1. If the swelling is mild and there are no symptoms, follow up. (B)
2. If an abscess has formed and symptoms are severe, a puncture and incision should be performed, followed by bacterial culture testing and administration of antibiotics. (B)
3. If a solid mass is detected, a histological examination is performed. (B)
4. Perform marsupialization for symptomatic cysts and abscesses. (B)
5. Excision is performed in cases of repeated abscess recurrence, cases of recurrence after marsupialization, and cases in which the presence of a tumor is suspected. (B)

CQ224 What is the follow-up after gynecological cancer treatment?

Answer

1. The approximate intervals for follow-up observation are every 1 to 3 months for the first to second years, every 3 to 6 months for the third year, every 6 months for the fourth to fifth years, and 1 year from the sixth year onward. (C)
2. Perform medical interviews, visual and palpatory examinations, pelvic examinations, rectal examinations, cytology, chest X-ray examinations, blood and biochemical tests, tumor markers, ultrasound examinations, computed tomography (CT) examinations, etc. (C)

CQ225 After treatment of gynecological malignant tumors (including borderline and low-grade tumors), is hormone replacement therapy (HRT) possible when ovarian function has ceased or decreased?

Answer

1. The decision to perform the procedure is made after considering the cancer type, histological type, degree of differentiation, advanced stage, age, complications, etc. (B)
2. It is not performed for recurrent endometrial cancer or low-grade endometrial stromal sarcoma. (B)
3. It can also be used for uterine cancer if it is determined that there is a high possibility of good treatment efficacy. (B)

CQ226 How is breast cancer screening performed?

Answer

1. Perform mammography screening for women over 40 years old. (A)
2. Ultrasound examination is also available for optional medical examinations for women over 40 years of age. (C)
3. For women over 40 years of age, perform a combined mammography and ultrasound examination. (C)
4. For women under 40 years old, perform ultrasound examination or combined ultrasound and mammography examination. (C)
5. The screening interval should be 1 to 2 years. (B)

CQ227 How is mastopathy managed?

Answer

1. Clinically, the diagnosis of "mastopathy" cannot be easily given as a diagnosis to exclude breast cancer. It is simply "suspicion of mammary gland disease". (B)
2. As a general rule, it is recommended to consult a specialized facility. (B)

3. Histologically diagnosed proliferative lesions without atypia are at risk of developing breast cancer and require regular screening. (B)
4. Histologically diagnosed atypical hyperplasia (ductal, lobular) clearly has a high risk of developing breast cancer, and a history of such hyperplasia is a risk factor for breast cancer. Closely follow up in cooperation with specialized facilities. (A)

CQ228 How do we treat cases suspected of familial cancer?

Answer

1. Gynecological-related familial tumors that should be kept in mind include Hereditary Breast and Ovarian Cancer syndrome (HBOC) and Lynch syndrome. The familial tumor history up to second-degree relatives should be investigated. (C)
2. In cases in which a familial tumor is suspected, options such as genetic counseling and genetic testing should be suggested to the patient and the patient should be referred to facilities capable of performing these services. (B)

CQ229 What are the considerations for outpatient management of febrile neutropenia during cancer treatment?

Answer

1. Use the Multinational Association for Supportive Care in Cancer (MASCC) score to assess the risk of increasing severity. (B)
2. In cases with a low risk of increased severity, oral antimicrobial drugs can be administered on an outpatient basis. (C)

CQ230 What should I do if I only see an increase in tumor markers and visit the gynecology outpatient clinic?

Answer

1. A medical interview, physical examination, pelvic examination, and ultrasound examination are performed to confirm that there are no organic abnormalities related to malignant tumors. (B)
2. CA125 levels are transiently elevated during menstruation, so measurements should be made at other times. (B)
3. If an organic abnormality related to a malignant tumor is suggested, the patient should be referred to a specialized medical institution or an available medical institution. (B)

ENDOCRINOLOGY AND INFERTILITY

CQ301 What should be noted when examining abnormal genital bleeding in sexually mature women?

Answer

1. Check for possible pregnancy. (A)
2. Check for vulvar, vaginal, and uterine-vaginal lesions. (A)
3. Bleeding from the cervix or uterine cavity is determined to be abnormal uterine bleeding (AUB)*. Diagnosis is performed by systematically differentiating organic (PALM: endometrial polyp, uterine adenomyosis, uterine leiomyoma, malignant tumor or endometrial hyperplasia) and non-organic (COEIN: coagulopathy, ovulation disorder, endometrial dysfunction, iatrogenic, other) diseases according to the PALM-COEIN classification. (A)

CQ302 What points should be considered when diagnosing menstrual cycle abnormalities?

Answer

1. Check for pregnancy. (A)
2. A detailed interview should be conducted to examine menstrual status over the past few cycles, as well as changes in the body and lifestyle. (A)
3. The patient should be enquired about their medication intake (psychiatry, internal medicine, etc.) and whether they have any symptoms of thyroid disease. (B)
4. Check for galactorrhea. (B)
5. Check for symptoms of hyperandrogenism, such as hirsutism and acne. (B)
6. Observe the uterus and ovaries using ultrasound. (B)
7. Measure Follicle stimulating hormone (FSH), Luteinizing hormone (LH), Estradiol (E2), Prolactin, (PRL), and thyroid stimulating hormone (TSH). (B)

CQ303 How do we treat menstrual cycle abnormality due to ovulation disorder?

Answer

1. Provide lifestyle guidance regarding sleep and appropriate weight. (B)
2. If the patient does not currently wish to have children,

- For oligomenorrhea or first-degree amenorrhea, administer progestin periodically. (B)
- Conduct estrogen/progestin therapy for second-degree amenorrhea. (B)
- Depending on the situation, use oral contraceptive (OC) or LNG-IUS. (C)

3. Currently, if the patient wishes to have a child, she should undergo infertility treatment, including ovulation induction. (B)

CQ304 How to regulate the menstrual cycle?

Answer

1. To shorten the period, administer EP combination drugs or OC for at least 10 days from the third to fifth day of the menstrual cycle. (B)
2. In the case of prolongation, during the follicular phase, medium-dose EP combination drugs or OC should be initiated within 7 days of menstruation and administered until the desired delay. (B)
3. When extending the period, check for pregnancy during the luteal phase, and administer medium-dose EP combination drugs or norethisterone from 5 to 7 days before the expected menstruation until the desired delay. (B)

CQ305 How do we treat functional dysmenorrhea?

Answer

1. Treat symptomatically with analgesics (NSAIDs, etc.). (B)
2. If analgesics (such as NSAIDs) are insufficiently effective, use low-dose estrogen/progestin combinations, progestin preparations, or levonorgestrel-releasing intrauterine systems. (B)
3. Administer herbal medicine or antispasmodic drugs. (C)

CQ306 What medications are available for chronic abnormal uterine bleeding (including menorrhagia) without organic disease?

Answer

1. Administer low-dose or moderate-dose estrogen/progestin combinations. (B)
2. Using a LNG-IUS. (B)
3. Administer an antifibrinolytic drug (tranexamic acid). (C)

CQ307 What is the drug therapy for acute abnormal uterine bleeding without organic disease?

Answer

1. Simultaneously administer estrogen and progestin. (C)
2. Administer antifibrinolytics (tranexamic acid). (C)
3. Administer estrogen preparations. (C)
4. Administer progestin preparations. (C)

CQ308 What treatments, other than pharmacotherapy, are available for acute abnormal uterine bleeding without organic disease?

Answer

Use one method or a combination of the following: (B)

1. Perform tamponade with an intrauterine balloon.
2. Perform uterine evacuation.
3. Perform UAE.
4. If fertility preservation is not necessary, hysterectomy or endometrial ablation is performed.

CQ309 What are the points to keep in mind when examining adolescent patients?

Answer

1. As the interview is important, conduct the interview not only with family members present but also with the patient alone. (B)
2. Even in the patient has not had sexual intercourse, a visual examination, rectal examination, and ultrasonography (transrectal or transabdominal) are performed if an important disease is predicted. (B)
3. Endometriosis, which primarily involves peritoneal lesions should also be considered. (B)
4. Patients with abnormal menstrual cycles should be evaluated the possibility of pregnancy or eating disorders. (B)

CQ310 What are the points to keep in mind when treating menstrual abnormalities in adolescent patients?

Answer

1. In cases of secondary amenorrhea progestin therapy is used for first-degree amenorrhea, or estrogen-

progestin therapy is used for low or no basal estrogen levels. (C)
2. Pay attention to low bone density in prolonged amenorrhea. (C)
3. Functional dysmenorrhea or organic dysmenorrhea that does not require surgical treatment, especially pain due to juvenile endometriosis, should be treated with either NSAIDs, antispastic drug or low-dose estrogen-progestin. (B)

CQ311 How do we provide consultations for delayed menarche?

Answer

1. Conduct an interview to determine medical his- tory, family history, patterns of daily life (e.g., diet, exercise), factors related to the growth process such as height and weight, and menstrual status. (A)
2. In cases in which menarche has not occurred by age 15, perform a detailed examination. (A)
3. Perform and examination to determine the presence and degree of development of secondary sex characteristics and the morphology of both internal and external sex organs. (A)
4. Perform endocrinological tests. (A)
5. In cases of suspected chromosomal abnormalities and hereditary disease, perform genetic testing such as chromosomal analysis. (C)

CQ312 How should weight loss-associated amenorrhea be treated?

Answer

1. Severity is assessed from height and weight. (A)
2. If anorexia nervosa is suspected, refer to a specialist doctor. (B)
3. Perform an endocrinological examination. (B)
4. Aim for recovery up to 90% of normal weight. (B)
5. In cases of long-term hypoestrogen status, bone mass is estimated and hormone therapy is administered. (B)
6. As a general rule, hormone therapy to induce menstruation is not performed when the patient is underweight. (B)
7. Ovulation induction is performed when a woman wishes to become pregnant and her general condition has improved. (B)

CQ313 How should premature ovarian insufficiency be handled?

Answer

1. Accurately conduct medical interviews. (A)
2. Perform endocrinological tests, etc. (B)
3. If the patient wishes to have children, refer them to a specialist as soon as possible. (B)
4. If the patient does not wish to have children, perform HRT. (B)
5. Counseling, including psychological support, should be provided when necessary. (C)

CQ314 What is the management of turner syndrome?

Answer

1. For patients diagnosed before or during puberty, consult a specialist physician regarding indications for growth hormone therapy. (A)
2. In growth hormone-treated patients, low-dose estrogens should be initiated after 12 years of age and at the latest by 15 years of age when height is 140 cm, in consultation with a specialist physician. (B)
3. Patients who have already reached adult height or who are not candidates for growth hormone therapy should be treated with HRT as in adults. (A)
4. Fertility should be explained with due consideration through counseling. (B)
5. Perform timely examinations and treatment for complications, such as thyroid dysfunction, glucose intolerance, aortic coarctation, and gonadal tumors. (B)

CQ315 What is the management of 46,XY disorder of sex differentiation?

Answer

1. Provide appropriate counseling to patients and parents after the diagnosis is confirmed. (B)
2. Considering the possibility of gonadal tumor development, strict follow-up should be performed, and prophylactic gonadectomy should be performed at the appropriate time. (A)
3. Androgen insensitivity syndrome should be treated with estrogen replacement therapy after castration. (A)
4. Since XY pure gonadal dysgenesis has a uterus, HRT, including progesterone preparations, is performed from the time of diagnosis. (A)

CQ316 How do we diagnose congenital uterine abnormality?

Answer

1. A detailed interview should be conducted regarding the following accompanying symptoms. (A)

(1) Amenorrhea, (2) dysmenorrhea or postmenstrual abdominal pain, (3) postmenstrual bleeding, (4) history of miscarriage or infertility, (5) pelvic mass or endometriosis, (6) concomitant malformations of the urinary tract, skeleton, or auditory system.

2. Perform the following tests as appropriate for diagnosis

- Vaginal speculum examination/internal examination (or rectal examination) (A)
- Transabdominal and transvaginal (or transrectal) ultrasound (A)
- Pelvic MRI examination (B)
- Hysterosalpingography (B)
- Hysteroscopy (C)
- Laparoscopy (C)

3. In cases where infertility and infertility are involved, general tests for infertility and infertility are performed at the same time. (B)

CQ317 How do we manage Mayer–Rokitansky–Küster–Hauser syndrome?

Answer

1. When sufficient counseling and follow-up can be provided, explain menstruation, fertility, and sexual intercourse to an extent that the patient can understand. (A)
2. Vaginostomy is performed based on the patient's wishes after sufficient counseling. (A)
3. If vaginal surgery is to be performed, refer the patient to an experienced facility. (A)
4. Counseling regarding sexual function and sexual psychology should be provided as necessary. (C)

CQ318 What is the primary test to find the cause of infertility?

Answer

Perform the following inspections.

1. Basal body temperature measurement (B)
2. Ultrasound examination (A)
3. Endocrine test (B)
4. Chlamydia antibody test or nucleic acid amplification test (B)
5. Fallopian tube patency test (B)
6. Semen analysis (A)
7. Cervical factor test (B)

CQ319 How should subclinical hypothyroidism and/or thyroid autoantibody positivity found during infertility/infertility treatment be handled?

Answer

1. The presence or absence of thyroid autoantibodies, blood TSH, fT4 levels, and infertility treatment methods are comprehensively determined, and L-T4 supplementation is performed as necessary. (C)
2. If necessary, manage the disease in collaboration with a specialist in thyroid diseases. (B)

CQ320 How do you treat unexplained infertility?

Answer

1. Testing and treatment policies are proposed considering the woman's age, period of infertility, social background, etc. (A)
2. We should explain pathological conditions that cannot be identified in the primary examination and perform secondary examinations to clarify the cause. (B)
3. Considering the woman's age and period of infertility, select the following: (C)
   - Perform 6 to 12 cycles of standby therapy, including timing guidance.
   - Perform ovulation induction treatment, artificial insemination, or a combination therapy.

- Suggest assisted reproduction early.

CQ321 How do we treat male infertility?

Answer

1. It is recommended that the cause of male infertility be investigated in collaboration with an urologist. (B)
2. Drug therapy for oligozoospermia. (C)
3. Intrauterine insemination (IUI) is performed for mild oligozoospermia and asthenozoospermia. (B)
4. Perform in vitro fertilization or intracytoplasmic sperm injection for severe oligozoospermia and asthenozoospermia. (B)
5. When treating azoospermia/severe oligozoospermia, the treatment policy is determined by consulting a urologist who is experienced in treating male infertility. (B)
6. If it is considered difficult to conceive using the husband's sperm due to azoospermia, etc., artificial insemination with donor's semen can be selected. (C)
7. 7. For sexual dysfunction, such as erectile and ejaculatory dysfunction, treatment is provided in cooperation with an urologist. (B)

CQ322 What steps should be followed when abnormal findings are found in the fallopian tubes in hysterosalpingography?

Answer

1. In cases of interstitial portion of the fallopian tubal obstruction findings, exclude functional atresia. (B)
2. In cases of bilateral proximal fallopian tubal obstruction, consider selective tubal hydration, falloposcopic tuboplasty, or in vitro fertilization. (B)
3. If peritubal adhesions, fimbrial adhesions, or hydrosalpinx are suspected, perform surgery, such as laparoscopic surgery. (C)
4. If the patient has hydrosalpinx and does not get pregnant after embryo transfer, surgery to the fallopian tubes should be considered. (B)

CQ323 How do we treat hyperprolactinemia?

Answer

1. Cases with pituitary apoplexy, tumors with visual impairment, or refractory/intolerant to drug therapy should be referred to neurosurgery. (B)
2. For drug-induced hyperprolactinemia, consult the doctor who prescribed the medication to either reduce the dosage or discontinue the problematic drug. (B)
3. In case with hypothyroidism, treatment with thyroid hormone replacement is recommended. (B)
4. Patients indicated for treatment that do not correspond to Answers 1–3 should be treated with dopamine agonists. (A)

CQ324 What are the precautions for ovulation induction for infertility with ovulatory disorders? (excluding assisted reproductive technology(ART))

Answer

1. Identify the type of ovulation disorder and select a treatment method. (A)
2. Aim for single ovulation. (B)
3. Monitor follicle development. (B)
4. If there are 4 or more follicles larger than 16 mm, cancel the treatment cycle. (B)
5. If hyperovulation occurs, check for ovarian hyperstimulation syndrome and multiple pregnancy. (B)

CQ325 What points should be considered when performing artificial insemination?

Answer

1. Perform shortly before ovulation to just after ovulation. (B)
2. Use a washed and concentrated sperm suspension. (B)
3. Perform ovulation stimulation with clomiphene citrate or gonadotropin preparations to improve the pregnancy rate. (C)
4. If IUI does not lead to pregnancy, ART is performed. (B)
5. Inform patients regarding the associated adverse events, which may include bleeding, pain, and infection. (B)

CQ326 How do you diagnose and treat polycystic ovarian syndrome?

Answer

1. Diagnosis is based on the diagnostic criteria of the Japan Society of Obstetrics and Gynecology (2007). (A)
2. For women who do not wish to have children.
   - If the patient is obese, provide lifestyle guidance, such as weight loss. (B)
   - Cause periodic withdrawal bleeding. (B)
3. For women who wish to have children

- Recommend weight loss if obese. (B)
- To induce ovulation, first perform clomiphene citrate therapy. (B)
- If obesity, glucose intolerance, or insulin resistance is observed and follicular development is not observed with clomiphene alone, metformin hydrochloride is used in combination. (B)
- If the patient is resistant to clomiphene citrate, perform gonadotropin therapy or laparoscopic ovarian surgery. (B)
- When administering gonadotropin therapy, stimulate slowly at low doses. (B)

4. Use aromatase inhibitors to induce ovulation. (B)

CQ327 How to prevent and manage the onset and severity of OHSS?

Answer

(Prevention: both general infertility treatment and ART)

1. When using gonadotropins in patients at high risk for ovarian hyperstimulation syndrome (OHSS), start at low doses. (B)
2. If the risk of OHSS is determined to be high during ovarian stimulation, hCG administration should be discontinued. (B)

(Prevention: ART)

3. If it is determined that the risk of OHSS is high before or during ART, one or more of the following measures should be taken

- Use the GnRH antagonist method or the low ovarian stimulation method. (B)
- Use GnRH agonist instead of human chorionic gonadotrophin (hCG). (B)
- Reduce or postpone hCG administration (coasting method). (B)
- Freeze the whole embryo. (B)
- Perform luteal replacement therapy using a progestin preparation alone. (A)

4. The following drug therapy should be added to prevent the disease from worsening after egg retrieval

- Cabergoline (B)
- Letrozole (C)
- GnRH antagonist formulation (C)

(management)

5. Patients with mild symptoms should drink lots of fluids and refrain from strenuous exercise. (C)
6. It is recommended that patients with moderate or higher symptoms and pregnant women be managed at a specialized medical institution. (B)
7. In principle, hospitalization is recommended for critically ill patients. (B)

CQ328 What steps should be followed when asked about fertility preservation for female patients suffering from malignant tumors, etc.?

Answer

1. The appropriateness of fertility preservation should be discussed with the physician-in-charge of the underlying disease, in accordance with the Japan Society of Obstetrics and Gynecology. (A)
2. For patients who wish to have eggs, fertilized eggs, or ovarian tissue cryopreserved, refer to reproductive medical facilities that can handle them. (B)

CQ329 How should chromosomal abnormalities related to recurrent miscarriage be handled?

Answer

1. Genetic counseling should be provided when performing chromosome testing for couples with recurrent miscarriage. (B)
2. Genetic counseling should be provided for chromosome testing of miscarriage villus tissue. (B)
3. When performing preimplantation genetic testing for recurrent miscarriage, it should be performed in accordance with the Japan Society of Obstetrics and Gynecology. (A)

HEALTHCARE FOR WOMEN

CQ401 How do we explain when prescribing low-dose OC and LEP?

Answer

In accordance with the "OC/LEP Guidelines 2020 Edition" (edited by the Japan Society of Obstetrics and Gynecology/the Japan Society for Menopause and Women's Health), conduct an interview using a check sheet. After excluding and considering contraindications and cases requiring special consideration, provide the following information:

1. OC is one of the most effective reversible contraceptive methods and is also highly safe. (B)
2. OC/low-dose estrogen/progestin (LEP) improve dysmenorrhea and heavy menstrual bleeding. (B)
3. LEP containing drospirenone is effective for premenstrual dysphoric disorder. It can also have an effect on premenstrual syndrome (PMS) (see CQ405). (B)
4. Compared to cyclic administration, continuous administration can improve dysmenorrhea and avoid symptoms associated with monthly withdrawal bleeding and withdrawal. (C)
5. OC can manipulate menstruation (see CQ304). (C)
6. OC/LEP cannot prevent sexually transmitted infections. (B)
7. Gastrointestinal adverse effects, such as nausea, may occur. It does not contribute to weight gain. (B)
8. The incidence of venous thromboembolism (VTE) is slightly increased compared to that in non-users; however, is lower than the incidence in pregnant women and puerperal women. If (abdominal pain, chest pain, headache, eye problems, severe leg pain [ACHES]) symptoms associated with VTE are observed, the patient should immediately stop taking OC/LEP and the prescribing doctor should be consulted. The risk of stroke increases if there is high blood pressure or migraine, and the risk of myocardial infarction increases if there is high blood pressure or if the patient is a smoker. (B)
9. The frequency of ovarian cancer, endometrial cancer, and colorectal cancer decreases. (B)
   - Cervical cancer and breast cancer may increase slightly. (C)
10. When visiting other departments, instruct patients to inform the attending physician that they are taking OC/LEP. (B)
11. Provide information on the need for perioperative drug withdrawal. (B)

CQ402 What precautionary measures should be followed when using OC/LEP in patients infected with SARS-CoV-2?

Answer

1. In severe or moderate cases, discontinue oral administration of OC/LEP. (B)
2. If the symptoms are mild or asymptomatic, oral administration of OC/LEP can be continued (there is no need to change to a single progestin preparation) (B)

<Refer to CQ410 regarding HRT>

CQ403 What are the instructions for installing the intrauterine contraceptive device/LNG-IUS?

Answer

Explain the following:

1. If the purpose is to prevent pregnancy, complete contraception cannot be achieved. (A)
2. If you suspect that you are pregnant, see a doctor immediately. (A)
3. Regular visits should be made to confirm the correct position and for replacement. (A)
4. Adverse events, such as bleeding, infection, perforation, and spontaneous shedding, may occur. (B)

CQ404 How to implement emergency contraception and what are the points to be considered?

Answer

Provide information on EC and implement it as necessary, as per the Japan Society of Obstetrics and Gynecology's "Guidelines for Proper Use of Emergency Contraception (revised edition in 2016)."

1. Ensure that one 1.5 mg tablet of LNG monotherapy is taken as soon as possible within 72 h after intercourse. (B)
2. As an alternative to oral administration, the Cu-IUD should be used within 120 h after intercourse. (B)
3. We should explain that the effects of EC are not perfect and that there is a possibility of pregnancy even after the procedure, and we should ask patients to visit the hospital to confirm pregnancy if necessary. (A)
4. Patients should be guided regarding the selection of reliable contraceptive methods when LNG oral administration is used for EC. (B)

CQ405 How do we diagnose and manage PMS?

Answer

1. Diagnosis is based on the time of onset, physical symptoms, and mental symptoms. (A)
2. Provide counseling, lifestyle guidance, and exercise therapy. (B)
3. Prescribe diuretics and herbal medicines. (C)
4. Prescribe drospirenone/ethinyl estradiol tablets. (B)
5. If psychiatric symptoms predominate, treat with selective serotonin reuptake inhibitors (SSRIs). (B)
6. If psychiatric symptoms are severe, refer to a psychiatrist or psychosomatic medicine facility. (C)
7. For premenstrual exacerbations of existing diseases, ovulation suppression should necessarily be performed in collaboration with the doctor in charge of the existing disease. (C)

CQ406 What are the medical considerations for female athletes?

Answer

1. If a patient visits the hospital with the chief complaint of amenorrhea, the patient should be examined considering the possibility of lack of available energy or osteoporosis. (A)
2. In the case of hypothalamic amenorrhea due to lack of available energy, increase energy intake and decrease energy expenditure through exercise. (A)
3. If the LH level does not rise and menstruation does not resume even after the treatment mentioned in Answer 2, hormone therapy is performed. (C)
4. If an eating disorder is suspected, refer to a specialist. (B)
5. Treatment for paramenstrual symptoms and amenorrhea should be administered considering the schedule of games and practices. (C)
6. Adjust the menstrual cycle considering changes in condition due to the menstrual cycle. (C)
7. When prescribing, athletes should be asked to check the latest international standards of the World Anti-Doping Code Prohibited List. (B)

CQ407 What points should be considered while diagnosing menopause?

Answer

1. This disease is suspected when a menopausal woman presents with various symptoms. (A)
2. At the time of diagnosis, comprehensively evaluate the following items. (B)

- Decrease in ovarian function.
- Physical changes associated with aging.
- Mental/psychological factors.
- Sociocultural environmental factors.

3. Rule out the existence of an obvious organic disease that causes the chief complaint. (B)
4. Keen attention should be paid to thyroid disease and depression because of similarities in symptoms and age of onset. (B)

CQ408 How to deal with menopausal disorders?

Answer

1. Listen to the patient's complaints while expressing acceptance and empathy. (B)
2. If there are problems with lifestyle habits, guide them to improve them. (C)
3. Provide psychotherapy, such as counseling and cognitive-behavioral therapy. (C)
4. If the main symptoms are hot flashes, sweating, and insomnia, HRT should be used. (B)
5. HRT uses only estrogen if the woman has had a hysterectomy, or estrogen and progestin if she has a uterus. (A)
6. Herbal therapy is used when patients complain of a variety of symptoms called indeterminate complaints. (C)

CQ409 What are the explanations for adverse events of HRT?

Answer

1. The following symptoms should be explained as minor problems. (A)

Uterine bleeding, breast pain/feeling of breast engorgement, migraine.

2. The following are diseases that may be increased by HRT. (B)
3. Coronary artery disease, stroke, VTE, breast cancer, ovarian cancer.
4. Patients who can be treated with caution or conditionally should be provided an explanation with reference to the 2017 Guidelines for Hormone Replacement Therapy. (B)
5. Adverse events of HRT vary depending on the patient's age, number of years after menopause, presence or absence of comorbidities, type/amount/duration/route of estrogen used, and use of concomitant progesterone. (B)

CQ410 What precautions should be taken when using HRT in patients infected with SARS-CoV-2?

Answer

1. Discontinue HRT in severe or moderate cases. (B)
2. HRT can be continued if symptoms are mild or asymptomatic. (B)

<For OC/LEP, please refer to CQ402>

CQ411 How should drug therapy be conducted for psychiatric symptoms of menopause?

Answer

1. HRT is used for menopausal symptoms accompanied by depressive symptoms. (B)
2. If psychiatric symptoms are severe, consider using psychotropic drugs. (C)
3. Antidepressants, such as SSRIs and serotonin and noradrenaline reuptake inhibitor, are used to treat depression during menopause. (C)
4. Patients with suicidal ideation, suspected bipolar disorder, or poor response to pharmacotherapy should be referred to a specialist, such as a psychiatrist. (A)

CQ412 What Kampo (Japanese herbal medicine) and complementary and alternative medicines are used on menopausal disturbance?

Answer

1. Tokishakuyakusan, Kamishoyosan, Keishibukuryogan, etc. are mainly used for herbal medicine prescriptions. (C)
2. Soybean isoflavones are used to treat hot flashes. (C)
3. Check for adverse events associated with Japanese herbal medicine and complementary and alternative medicine. (B)

CQ413 How to manage female sexual dysfunction?

Answer

1. Check for the symptoms of female sexual dysfunction and classify the pathology. (B)
2. Confirm the presence or absence of drugs or diseases that affect sexual function. (B)
3. For dyspareunia and insertional dysfunction due to organic causes or estrogen deficiency, recommend the

use of lubricating jelly, estrogen replacement, and other treatments depending on the cause of the issue. (C)
4. If specialized treatment, such as counseling, is required, the patient should be referred to a specialist doctor.

CQ414 How do we assess the risk of lifestyle related diseases in women after menopause?

Answer

1. Ask the patient about her family history of lifestyle-related diseases, abnormal test results, whether she smokes, and whether she has had any complications during pregnancy or at a young age. Measure blood pressure, height, and weight to assess risk. (A)
2. If there is a risk of dyslipidemia, categorization is performed based on serum lipid testing and absolute risk assessment (see CQ415). (B)
3. If there is a risk of hypertension, evaluate by measuring blood pressure at home in addition to in-office blood pressure. (B)
4. If there is a risk of diabetes, diagnose by measuring blood sugar level and HbA1c. (B)
5. If there is a risk of chronic kidney disease (CKD), measure urine protein and serum creatinine. (B)
6. If dyslipidemia, hypertension, diabetes, or CKD is observed, other diseases should be evaluated and managed. (B)

CQ415 How should women with dyslipidemia be treated?

Answer

1. Diagnose based on the dyslipidemia diagnostic criteria (Japan Atherosclerosis Society Guidelines for Prevention of Atherosclerotic Cardiovascular Diseases 2022). (B)
2. For high-risk patients, such as those with secondary prophylaxis for prior coronary artery disease or atherothrombotic stroke or suspected familial hypercholesterolemia, refer to a specialist in internal medicine. (B)
3. Set the lipid control target value according to the management category according to the risk in primary prevention. (B)
4. Initially, the patient should receive 3–6 months of guidance focusing on improving lifestyle habits (smoking cessation, diet, and exercise habits), and if management goals cannot be achieved, concomitant drug therapy should be considered depending on the risk. (A)
5. After menopause, in addition to lifestyle improvements, drug therapy is also recommended in consideration of risk factors, such as diabetes and CKD. (B)
6. For drug therapy, HMG-CoA reductase inhibitors (statins) are mainly used for hyperLDL-Cemia, and fibrates are used for hypertriglyceridemia. (B)
7. If the patient has menopausal symptoms, administer HRT hoping for lipid metabolism improvement. (C)

CQ416 How to prevent osteoporosis?

Answer

1. For younger individuals, adequate calcium intake and vigorous exercise are recommended to achieve maximum bone density. (B)
2. For middle-aged and elderly patients, continuous exercise, such as weight-bearing exercise and walking, is recommended. (B)
3. Encourage intake of foods rich in calcium, vitamin D, and vitamin K. (B)
4. Recommend bone densitometry in patients aged 65 years or older, and in postmenopausal women <65 years with fracture risk factors (excessive alcohol consumption, current smoking, family history of fractures, steroid use, etc.). (B)
5. HRT is performed after long-term second-degree amenorrhea, premature ovarian failure, and premenopausal bilateral oophorectomy. (B)
6. HRT is performed after menopause. (C)

CQ417 How to diagnose and start treatment for postmenopausal osteoporosis?

Answer

1. Check for secondary osteoporosis and diseases other than osteoporosis that cause low bone density. (B)
2. Diagnosis is made based on the presence or absence of fragility fractures confirmed by spinal X-ray images and bone density values determined by dual-energy X-ray absorptiometry. (B)
3. Drug therapy can be started even if the diagnostic criteria for osteoporosis are not met as long as the criteria for starting drug therapy are met. (B)
4. Fracture risk should be comprehensively evaluated using the fracture risk assessment tool FRAX® and other risk factors. (C)

CQ418 What is the drug treatment for postmenopausal osteoporosis?

Answer

1. The first choice for the treatment is bisphosphonates, followed by selective estrogen receptor modulators, denosumab (anti-RANKL antibody), or eldecalcitol. (A)

2. After discontinuation of denosumab, vertebral fractures may occur; therefore, sequential therapy with other bone resorption inhibitors is performed. (B)
3. Bone formation-promoting drugs, such as teriparatide and romosozumab, can be used for osteoporotic patients with a high risk of fracture, but referral to a specialist physician should be considered. (C)
4. Women with menopausal symptoms are treated with HRT using estrogen (conjugated estrogen, 17β-estradiol). (B)
5. Calcium preparations, active vitamin D3 preparations, and vitamin K2 preparations can be used in combination with the main therapeutic drug depending on the disease state. (C)

CQ419 How do we prevent and manage the symptoms and diseases that occur after treatment for gynecologic cancer?

Answer

1. If ovarian dysfunction occurs before natural menopause
   - Check for the development of hypertension, dyslipidemia, and diabetes. (C)
   - To prevent osteoporosis, improve daily life and implement drug therapy from an early stage. (B)
   - Explain to the patient that HRT after treatment for gynecological cancer, which is expected to be curable, can be continued for a long period without affecting cancer recurrence. (B)
2. Check for locomotive syndrome and frailty in elderly cancer survivors. (C)
3. Check for female lower urinary tract symptoms (FLUTS) and genital symptoms. (C)
4. Strive to prevent the onset and severity of lymphedema. (B)

CQ420 How do we diagnose and treat non-infectious vulvar pruritus?

Answer

1. First, confirm whether it is an acute or chronic disease and whether there is an infection (see CQ107, 108)

If the infection is ruled out, conditions, such as contact dermatitis, atrophic changes (see CQ421), skin specific diseases, neoplasms, systemic diseases, psychogenic reactions, etc. should be considered. (B)

2. If there is a possibility of contact dermatitis, remove possible irritants and allergens from the interview venue. (B)
3. For mild cases, use skin moisturizers and nonsteroidal anti-inflammatory topical agents. (C)
4. For moderate to severe symptoms, use topical steroids. (B)
5. If no improvement is observed, suspect another disease and refer the patient to a specialist. (B)

CQ421 How do you manage discomfort in the vagina/vulva in a postmenopausal woman?

Answer

1. Check for infection/inflammation, neoplastic lesions, and pelvic organ prolapse. (A)
2. Check for FLUTS. (B)
3. Recommend the use of topical moisturizers and lubricating jelly. (B)
4. Recommend the use of estrogen locally or systemically. (B)

CQ422 In the context of FLUTS (frequent urination, nocturia, urinary urgency, urinary incontinence, difficulty urinating, and bladder pain), what is the initial treatment?

Answer

1. Symptoms and medical history should be examined. A physical examination and a urinalysis should be performed. (A)
2. If residual urine is suspected, measure residual urine. (B)
3. Consider referral to a specialist physician if symptoms such as urinary symptoms, urinary retention, hematuria, stone ureter, pyuria, residual urine and neurological disease are present. (B)
4. If a gynecological disease is thought to be the cause, its treatment should be prioritized. (A)
5. Evaluate symptoms and quality of life (QOL) based on questionnaires and urination records (void diary). (C)

CQ423 How do we diagnose urinary incontinence?

Answer

1. Perform a baseline assessment of FLUTS. (A)
2. Differentiate stress urinary incontinence from urge urinary incontinence. (B)
3. A pad test, stress test, ultrasound examination should be performed. (C)
4. A urodynamic study should be performed by a specialist. (C)

CQ424 What is the treatment for stress urinary incontinence/mixed urinary incontinence?

Answer

1. Teach pelvic floor muscle training. (B)
2. Administer clenbuterol. (B)
3. Consider referral to a doctor specializing in urinary incontinence if the symptoms do not improve with the above treatments. (B)
4. Patients with concurrent symptoms of urge urinary incontinence should be treated according to the treatment for overactive bladder (see CQ425). (A)

CQ425 What is the outpatient management of overactive bladder?

Answer

1. Perform a baseline assessment of FLUTS. (A)
2. Assess using the Overactive Bladder Symptom score. (B)
3. Behavioral therapy, including bladder training and pelvic floor muscle training, should be administered. (B)
4. When drug therapy is used, anticholinergics or β3-adrenergic receptor agonists should be used. (A)
5. Administer HRT. (C)
6. Intractable cases should be referred to a specialist. (B)

CQ426 How do we diagnose pelvic organ prolapse?

Answer

1. The site and degree of pelvic organ prolapse should be evaluated using the pelvic organ prolapse quantification system (POP-Q) method. (B)
2. Diagnose other gynecological diseases. (A)
3. Evaluate urination, defecation, and sexual function using questionnaires, etc. (C)
4. If patients complain of lower urinary tract symptoms, respond according to the algorithm (see CQ422). (B)

CQ427 What is the treatment for pelvic organ prolapse?

Answer

1. Prescribe pelvic floor muscle training for symptomatic POP-Q stage I patients. (B)
2. Consider pessary therapy or surgical therapy for symptomatic POP-Q stage II or higher. (B)
3. After wearing the pessary, patients should be examined every 1 to 3 months for the first year and every 1–6 months thereafter to check its effectiveness and the presence of any adverse events. (B)
4. Instruct patients to wear and take off their pessaries by themselves to reduce the adverse effects of pessary therapy. (C)
5. For vaginal wall erosion after wearing a pessary, administer estriol vaginal preparation. (B)
6. In cases where outpatient management is difficult or at the patient's request, surgical therapy is performed with appropriate informed consent. (B)

CQ428 What is the initial response when a patient complains of gas or fecal incontinence?

Answer

1. 1.Inquire about the status of the incontinence, the characteristics of the feces, the patient's medical history, and comorbidities. (A)
2. Check for rupture of the anal sphincter. (B)
3. Teach pelvic floor muscle training. (B)
4. In cases of loose stool, provide solidification therapy. (B)
5. If QOL impairment is severe, the patient should be referred to a specialist doctor. (B)

CQ429 What should you do if you suspect intimate partner violence?

Answer

1. Ask the accompanying person to leave the room, and examine the victim. (A)
2. The following measures should be taken to ensure that medical certificates can be filled out as necessary. (A)
   - Interview in detail about the timing and circumstances of the injury and clinical symptoms and record them in the medical record.
   - If there is any trauma, obtain consent, confirm the trauma on the whole body, and record the findings.
3. If violence from a partner is confirmed, take the following actions
   - Listen receptively, be empathizing and careful to ensure that secondary damage is not caused. (A)
   - Provide information on spousal violence counseling and support centers, police, and counseling. (A)
   - If it is determined that it is necessary to ensure safety, encourage the person to consult the Spousal Violence Counseling and Support Center or the police. (A)
4. If the patient is of reproductive age and does not wish to become pregnant, provide information on reliable

contraceptive methods and use emergency contraception if necessary. (B)

CQ430 How should you respond to women who have experienced sexual violence?

Answer

1. Provide information on one-stop support centers for victims of sexual violence and police. (A)
2. If the patient is hesitant about whether they want the perpetrator to be punished, explain the importance of preserving evidence and refer them to a one-stop support center or encourage them to consult the police. (A)
3. If requested by the One-Stop Support Center or the police to perform a medical examination or preserve evidence, provide a full explanation of the necessity, etc., and after obtaining consent, take the following actions. (A)
   - Check for injuries to the whole body, especially injuries to the vagina, anus, oral cavity, and their surroundings, and record them accurately in the medical record, including imaging.
   - Collect evidence from possible contact areas.
   - Perform a sexually transmitted disease test.
   - If there is a possibility of drug use, collect blood and urine.
4. Even if a person does not wish to consult the One-Stop Support Center or the police, take the following actions to the extent that consent has been obtained. (A)
   - Check for injuries to the whole body, especially to the vagina, anus, oral cavity, and surrounding areas, and accurately record them in the medical record.
   - Perform a sexually transmitted disease test.
5. Emergency contraception is generally used during reproductive age. (A)
6. Counseling at a one-stop support center is recommended to prevent post-traumatic stress disorder. (C)

CQ431 How should you respond to girls suspected of being sexually abused?

Answer

1. Check for the following necessary medical findings and record them in the medical record. (A)
   - Injury on the whole body.
   - Injury to the vulva, vagina, or anus observed in a position suitable for girls, or findings observed after the injury has healed.
   - Sexually transmitted diseases.
   - Pregnancy.
   - Foreign body in the vagina.
2. In the acute stage, collect evidence from the body surface and inside the vagina. (A)
3. Information about the patient's words and demeanor during the consultation should be recorded in the medical record. (A)
4. If you have the medical findings listed in Answer 1 and have not notified the police or child consultation center, notify the child consultation center. (A)

CQ432 How should be hormone therapy for gender incongruence (gender identity disorder) handled?

Answer

1. When administering hormone therapy, a specialized medical team should confirm the diagnosis and determine whether treatment is appropriate before starting treatment. (A)
2. Information on expected effects and limitations, adverse events and their prevention/response, deterioration of ovarian or testicular function, and reproduction should be explained. (A)
3. For female-to-male (trans men), use androgen preparations. (B)
4. For male-to-female (trans women), use estrogen preparations. (B)
5. If there is significant discomfort in the development of secondary sexual characteristics, consider GnRH agonist preparations. (B)
6. During treatment, regular examinations and tests should be conducted to evaluate the effectiveness of medication and adverse events. (B)
7. At the stage where there is a discrepancy between appearance and the sex registered in the family register due to hormone therapy, etc., necessary support, such as writing a opinion, should be provided, to address difficulties in social life. (C)

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ACKNOWLEDGMENTS

The authors would like to thank Nozomi Yukawa, Yoko Sugiyama, Kiyo Okuzawa, Kazue Oshima (Fujita Health University Library) and Yamaguchi Naohiko (Library, Seirei Sakura Citizen Hospital)for analysis by systematic review.

CONFLICT OF INTEREST STATEMENT

Dr. Kyoko Tanaka, Dr. Akitoshi Nakashima, Dr. Yoshimitsu Kuwabara and Dr. Yoshihito Yokoyama are the Editorial Board members of *JOG* Journal and the co-authors of this article. Also, Dr. Hiroaki Kajiyama is the Editor-in-Chief of the journal. To minimize bias, they were excluded from all editorial decision-making related to the acceptance of this article for publication. Peer-review was handled independently by *JOG* Journal editorial office to minimize bias. Others have no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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How to cite this article: Nishio E, Ishitani K, Arimoto T, Igarashi T, Ishikawa T, Iwase A, et al. Guideline for gynecological practice in Japan: Japan Society of Obstetrics and Gynecology and Japan Association of Obstetricians and Gynecologists 2023 edition. J Obstet Gynaecol Res. 2024. https://doi.org/10.1111/jog.15950