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An Adolescent Guide for Parents

Primary and Preventive Health Care for Female Adolescents

Adolescence is a time of transition from childhood to adulthood, marked by a number of developmental milestones. For many, this passage is relatively smooth, for others, however, it may be a time of difficulty. Adolescent girls, in particular, are confronted with numerous challenges, and the decisions they make can have both short- and long-term consequences for their health and well being. The primary health risks to adolescents are no longer the traditional medical causes of illness; rather, they are behavioral. These risks include a sedentary lifestyle, poor nutritional habits, cigarette smoking, alcohol and illicit drug use, driving under the influence of alcohol, early initiation of sexual activity, and poor use of contraception. Most adolescents will engage in one of these unhealthy and risky behaviors, and data from the 1997 Youth Risk Behavior Surveillance Report indicate that nearly 1 in 12 adolescents engage in two or more of these risky behaviors, posing an even greater threat to their health and lives. Furthermore, 75% of all deaths among youth and young adults (10-24 years of age) in 1996 resulted from four preventable causes: motor vehicle crashes (32%); homicide (20%); suicide (13%), and other unintentional injuries (10%). Guidance from a physician can greatly facilitate a young girl's healthy transition to adulthood. Physicians can provide preventive guidance to both parents and adolescents. They can screen for health-risk behaviors and early disease and can either provide or refer patients for the necessary immunizations against infectious disease. This education bulletin will address female adolescent development and primary and preventive health care intervention, including timing of health care visits, health guidance for parents and adolescents, screening, and immunization.

I. Female Adolescent Development

The delivery of preventive services to adolescents differs from the delivery of preventive services to adults. Although diseases and behaviors among adolescents and adults may or may not be similar, an adolescent's unique developmental stage dictates the framing of preventive services. Furthermore, not all adolescents of the same age are at the same stage of development, thus necessitating further examination of the adolescent's physical, sexual, psychosocial, and cognitive development. Understanding the milestones and developmental stages of adolescence is beneficial to the obstetrician- gynecologist treating adolescents.

A. Sexual Development

Theharche, or breast budding, the first sign of secondary sexual development in most adolescent females, occurs for most young girls in North America at 8-10 years of age. Production of low amounts of estrogen stimulates long bone growth, with a peak height velocity of 9 cm per year. When higher levels of estrogen are produced, breast development progresses, long bone growth decelerates, and the epiphyses close. Menarche occurs during this deceleration phase. On average, the first menses occurs between 12-13 years of age, with regular ovulation established by approximately 20 cycles later. The average duration of puberty is 4 years, with a range of 1.5-8 years. Data from a large-scale cross-sectional study indicate that at every age and for the development of each pubertal characteristic, African-American girls are more advanced than white girls. Absence of theharche by age 13 years or menarche by age 15 years represents a 2.5 standard deviation from the mean and warrants evaluation. Likewise,

breast development at younger than age 8 years in the white population, or 7 years in the African-American population, is outside the range for normal development. In addition, tempo and sequence aberrancies during an otherwise established pubertal process should be included for evaluation of delayed or precocious sexual development.

B. Psychosocial and Cognitive Development

Adolescence is a prolonged period of transition during which a young person's expanding horizons, self-discovery, and quest for independence lead to the formation of a separate and distinct identity. It is particularly challenging because the processes of physical, psychologic, and cognitive development occur on separate tracks, with different timetables, which rarely are synchronous. Thus, the obstetrician-gynecologist often will encounter a young girl who has matured physically but not accomplished important psychologic and cognitive developmental tasks that will allow her to: 1) understand the consequences of present behaviors on future health outcomes and make crucial decisions about the future, understand the saliency of risks and internalize those risks, and 3) form and maintain stable and healthy relationships while evolving and learning to communicate a value system of her own.

The adolescent often believes that she is different from others and, therefore, not liable to the risks that threaten her peers. Although on an intellectual level these risks may be well understood, adolescent behaviors tend to reflect an assumption of invulnerability. Such egocentrism generally is outgrown with continuing cognitive development and a young person's perception of "self" relative to "others." As the girl progresses through adolescence, she becomes increasingly capable, both cognitively and emotionally, of comprehending abstract ideas, relating present actions to future outcomes, and understanding the consequences of her own behaviors. Thus, the clinical approach to counseling a younger adolescent will differ from the approach taken with an older adolescent or an adult.

II. Timing of Health Care Visits

A. Initial Visit

The obstetrician-gynecologist frequently is asked by adult patients at what age should their adolescent daughter visit an ob-gyn. The first visit to the obstetrician-gynecologist for health guidance, screening, and the provision of preventive health care services should take place between the ages of 13 and 15 years. Because the obstetrician-gynecologist can function as either a primary care physician or a consultant specialist, it is important to determine whether or not the adolescent patient has a primary care provider. If so, a collaborative relationship between physicians should be established. The exact timing and scope of the initial visit to the obstetrician-gynecologist will depend on the individual girl and her physical and emotional development. Parents and adolescent females should be reassured that the initial visit at this age serves primarily to establish rapport between the obstetrician-gynecologist and the young woman, and generally does not include a pelvic examination. This visit is an ideal opportunity to discuss with both parents and adolescents normal adolescent development and other concerns related to adolescence.

In order to provide optimum health care, physicians should discuss issues of confidentiality with both the adolescent and her parent(s). Confidentiality frequently is identified as a major obstacle to the delivery of health care services to adolescents. To overcome this barrier, physicians should initiate discussion of this topic, advise the adolescent patient and her parent(s) of relevant state and local statutes, and stress the importance of open communication between all parties.

Physicians are encouraged to consult other sources for an in-depth examination of the issues surrounding confidentiality. The provision of additional services beyond guidance and screening should be based on the information obtained at this initial visit. If the patient has had sexual intercourse, or if other gynecologic concerns exist, a pelvic examination, Pap test, and cervical screening for sexually transmitted diseases (STDs) are appropriate.

B. Annual Visits

Because the potential for unhealthy behaviors and poor health outcomes is significant during adolescence, the initial consultation visit should be followed by annual preventive health care visits. Annual visits contribute to the formation of a trusting relationship between the adolescent patient and her physician. This, in turn, eases the disclosure of high-risk behaviors and facilitates

the early diagnosis of physical and emotional disorders. Such visits also enhance the physician's credibility as a caring adult and, therefore, tend weight to recommendations that promote good health. Finally, annual visits enable the adolescent to assume increasingly greater responsibility for her health and well-being.

The proactive, annual preventive health care visit should focus on health guidance for both patient and parent(s), including a discussion of normal adolescent development; screening for physical, emotional, and behavioral conditions; and immunizations. Primary and preventive health care for adolescents should be based on the guidelines summarized in this bulletin. Physicians should tailor the content of their health guidance, screening, and level of parental involvement to the unique requirements of each patient. A physical examination is not required at every visit, but should be included at least once during early adolescence (12-14 years), middle adolescence (15- 17 years), and late adolescence (18-21 years). A pelvic examination should be performed on all adolescents who are either sexually active or older than 18 years and when indicated by the medical history (e.g. pubertal aberrancy, abnormal bleeding, or abdominal or pelvic pain). If the patient has had sexual intercourse, a Pap test and screening for STDs also are appropriate. To help adolescents navigate the transition from childhood to adulthood, a number of organizations have formulated guidelines for adolescent preventive health care services.

Guidelines for Adolescent Preventive Services (GAPS) developed for the American Medical Association by a national group of experts, including representatives from ACOG, forms the basis of the following recommendations. These recommendations are grouped into three categories: health guidance for both parents and adolescents, screening, and immunization.

III. Health Guidance

Periodic health guidance for parents and adolescents is a critical component of primary and preventive health care. This is different from obtaining the past medical history because it involves the counseling and discussion component of the health care visit. Health guidance provides an opportunity for physicians, adolescent patients, and their parents to address current and potential health care needs.

A. For the Parents

Parents and other adult caregivers should receive health guidance at least once during their child's early adolescence, once during middle adolescence, and preferably once during late adolescence. Such guidance can be provided either concurrent to the adolescent's visit or as a separate visit. Health guidance for parents includes information about the following areas:

1. Normal adolescent development, including information about physical, sexual, and emotional development
2. Signs and symptoms of common diseases and morbidities in adolescents, including depression and emotional distress, to alert parents to the potential health risks facing their children
3. Physical and psychosocial benefits gained from participation in sports and other supervised extra- curricular activities
4. Parenting behaviors that promote healthy adolescent adjustments:
 - Allowing increased autonomy and responsibility
 - Anticipating challenges to parental authority
 - Establishing jointly family rules and the consequences for breaking them, and enforcing those rules and consequences
 - Enhancing self-esteem with praise and recognition of positive behaviors and achievements
 - Minimizing criticism - Respecting privacy
 - Spending time with the adolescent
5. Ways to minimize potentially harmful behaviors by:
 - Monitoring and managing the adolescent's use motor vehicles
 - Avoiding weapons in the home or ensuring that adolescents follow weapon safety procedures
 - Removing weapons and potentially lethal medications from the home of a suicidal adolescent
 - Monitoring the adolescent's social and recreational activities, including the use of

- tobacco, alcohol, drugs, and sexual behavior particularly in early and middle adolescence
- Remaining involved in the adolescent's use of her free time, including television and interact usage, particularly in early and middle adolescence
- Monitoring peer relationships
- Recognizing their daughter's vulnerability in unequal relationships, such as
- those with older partners or when the partner is in a position of relative
- authority over the adolescent
- Encouraging the regular use of sunscreen

Additionally, it is important for parents to recognize the influential role of the media, particularly as a source of sexual information for adolescents. At an age when many girls experience a decline in self-esteem, youth-oriented magazines reinforce sexual stereotypes, emphasize physical appearances, and advise girls on attracting adolescent males. In these popular publications, sexually explicit materials and abstinence-only messages are included together, and little or no information is provided to help readers make healthy, safe, and responsible decisions. Such materials further contribute to the difficult choices that increasingly younger girls are forced to consider. Recognition of these sources of information can help both parents and physicians in their efforts to ensure the health of adolescent girls.

B. For the Adolescent

Adolescents should receive annual health guidance to promote a better understanding of their physical, psychosocial, and psychosexual development. Such guidance should emphasize health promotion and risk reduction strategies. The importance of becoming actively involved in decisions regarding their own health care also should be emphasized.

Screening provides an excellent opportunity to counsel adolescents about healthy lifestyles. Because of concerns regarding mutual trust, issues of confidentiality, and individual comfort levels when discussing sensitive topics, eliciting an accurate response can be difficult. Often, repeated questioning over time is necessary to obtain accurate and complete information. Health guidance for the adolescent is important. This discussion should address diet and physical activity, healthy sexual lifestyle, and injury prevention as follows:

1. Dietary habits, including ways to achieve a healthy diet and safe weight management
2. The benefits of physical activity and encouragement to engage regularly in safe physical activities
3. Responsible, consensual sexual behavior, including counseling on:

Abstinence from sexual intercourse and information that this method is the most effective way to prevent pregnancy and STDs, including HIV infection

 - HIV transmission and the dangers of the disease
 - The effectiveness of latex condoms in reducing the risk of pregnancy and STDs, including HIV infection
 - Responsible sexual behavior for adolescents who are not currently
 - sexually active and for those who are using birth control and condoms appropriately
 - Reducing the risk of sexual victimization and acquaintance rape, including the role of alcohol and other drugs
 - Information on emergency contraception, including the 24-hour, national toll-free hotline number 1-888-NOT-2-LATE
4. Prevention of injuries, including:
 - Avoiding the use of alcohol or other substances
 - Avoiding driving a motor vehicle or other recreational vehicle if the teen has consumed alcohol or other substances
 - Avoiding riding in a car or other recreational vehicle if the driver has consumed alcohol or other substances
 - Encouraging adolescents and their parents to develop agreements for picking-up adolescents who have consumed alcohol or other substances
 - Using safety devices, including seat belts, motorcycle and bicycle helmets, and appropriate athletic protective devices
 - Nonviolent conflict resolution

- Avoiding the use of weapons or promoting weapon safety
- Promoting appropriate physical conditioning before exercise

IV. Screening

A. Blood Pressure

All adolescents should be screened annually for hypertension according to the protocol developed by the National Heart, Lung, and Blood Institute Task Force on High Blood Pressure in Children and Adolescents. Although the incidence of hypertension in adolescence is low, early detection of elevated blood pressure and evaluation for hypertension risk factors may prevent later cardiovascular diseases. Body size is the single most important determinant of blood pressure in children and adolescents. By accounting for different levels of growth when evaluating blood pressure, a more precise classification can be made thus avoiding misclassification of those adolescents at the extremes for normal growth.

B. Cholesterol

Adolescents should be screened by history using the following guidelines to determine their risk of developing hyperlipidemia and adult coronary heart disease. Selected adolescents should have lipid testing according to the protocol developed by the Expert Panel on Blood Cholesterol in Children and Adolescents:

- Adolescents whose parents have a serum cholesterol level greater than 240 mg/dL should be screened for total blood cholesterol (non-fasting) at least once.
- Adolescents with either an unknown family history or multiple risk factors for future cardiovascular disease (e.g. smoking, hypertension, obesity, diabetes mellitus, excessive consumption of dietary saturated fats and cholesterol) may be screened for total serum cholesterol level (non-fasting) at least once at the discretion of the physician.
- Adolescents with blood cholesterol values less than 170 mg/dL should have the test repeated in 5 years. Those with values between 170 and 199 mg/dL should have a repeat test. If the average value of the two tests is below 170 mg/dL, total blood cholesterol level should be reassessed within 5 years. A lipoprotein analysis should be done if the average cholesterol value from the two tests is 170 mg/dL or higher, or if the result of the initial test was 200 mg/dL or greater.
- Adolescents who have a parent or grandparent with coronary artery disease, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death at age 55 or younger should be screened with a fasting lipoprotein profile.
- Treatment options are based on the average of two assessments of low-density lipoprotein cholesterol. Values below 110 mg/dL are acceptable; values between 110 and 120 mg/dL are borderline, and the lipoprotein status should be reevaluated in 1 year. Adolescents with values of 130 mg/dL or greater will need further evaluation.

C. Eating Disorders

All adolescents should be screened annually for eating disorders and obesity by determining weight and stature, calculating a body mass index (BMI), and asking about body image and eating patterns. For many young women, significant weight loss or preoccupation with dieting should alert the obstetrician-gynecologist to the possibility of an eating disorder. Additionally, test results of vital signs may help to confirm the suspicion of eating disorders and identify patients needing emergency hospitalization. The following general guidelines should be used:

- Adolescents should be assessed for organic disease, anorexia nervosa, or bulimia if any of the following are found:

- Amenorrhea or abnormal menses
- Refusal to maintain body weight at or above a normal weight for age and height
- Recurrent dieting when not overweight
- Use of self-induced emesis, laxatives, starvation, or diuretics to lose weight
- Distorted body image
- BMI below the 5th percentile

- Hypotension, bradycardia, cardiac arrhythmia, or hypothermia

D. Tobacco

All adolescents should be asked annually about their use of tobacco products.

Approximately 1 in 4 high school seniors currently uses tobacco, and females are as likely as males to be smokers. Screening for tobacco use should include the following:

- Adolescents who smoke or use any tobacco products should be assessed further to determine their pattern of use.
- A cessation plan should be provided for adolescents who smoke or use any tobacco products. Appropriate nicotine replacement therapy should be considered when there is strong evidence of nicotine dependence and a clear desire to quit tobacco use. - Because of an adolescent's preoccupation with body image, all teens should be counseled on the effects of smoking and use of other tobacco products on hair, skin, and breath.
- Counseling also should include long-term health consequences, including the possible impact on a female's reproductive potential.

E. Alcohol and Other Drugs

All adolescents should be asked annually about their use of alcohol and other drugs, including street drugs, over-the-counter and prescription drugs for nonmedical purposes, and inhalants. Substance abuse occurs frequently in adolescence, is a major factor in injuries and deaths among adolescents, and contributes to motor vehicle accidents, homicide, and suicide.

Screening for alcohol and drug use should include the following recommendations:

- Adolescents who report any use of alcohol or other drugs, or inappropriate use of medications during the past year should be assessed further regarding family history, circumstances surrounding use, amount and frequency of use, attitudes and motivation to use, use of other drugs, and the adequacy of physical, psychosocial, and school functioning.
- Adolescents whose substance use endangers their health should receive counseling and mental health treatment.
- Urine screening for drug use in adolescents without prior informed consent is not recommended and is illegal in many states.

F. Sexual Activity

All adolescents should be asked annually about involvement in sexual behaviors that may result in unintended pregnancy and STDs, including HIV infection. High rates of sexual activity, coupled with inconsistent use of contraception, contribute to the United States having one of the highest adolescent pregnancy rates in the developed world. Currently, 1 out of every 10 adolescent females aged 15-19 years becomes pregnant annually.

Adolescents should be counseled that abstinence is the only health choice that assures protection from STDs and pregnancy. Sexually active patients must be educated about the safety and efficacy of current contraceptive options. The most effective protection against unintended pregnancy and STDs, other than abstinence, includes a combination of latex condoms and hormonal methods of birth control. Adolescents also should be counseled about emergency contraception pills. Although emergency contraception pills can prevent unintended pregnancies after episodes of unprotected sexual intercourse or method failure, they afford no protection against STDs. Pregnant adolescents whose pregnancies are unintended (either mistimed or unwanted) should be counseled about pregnancy options, including adoption, raising the baby, or termination. The practitioner must be knowledgeable about local support services and state laws regarding parental notification and consent for elective termination of pregnancy. If the adolescent continues with the pregnancy, the importance of prenatal care should be emphasized, and appropriate follow-up care should be arranged. For pregnant school-aged adolescents, the importance of completing high school should be stressed. Screening for sexual activity should include the following points:

- Sexually active adolescents should be asked about their sexual orientation, partner use of condoms, contraceptive methods, number of current and previous sexual partners, exchange of sex for money or drugs, and history of prior pregnancy or STDs.

- Adolescents should be questioned about the age and the relationship with their partners to screen for possible sexual abuse.
- Adolescents at risk for pregnancy, STDs (including, HIV), or sexual exploitation should be counseled on how to reduce their risk.

G. Sexually Transmitted Diseases

Because most adolescent patients become sexually active prior to high school graduation, STDs are a major health issue for this population. Sexually transmitted diseases are the most common infectious diseases among adolescents, and as a group they are at greatest risk. Each year, nearly 4 million adolescents are infected with STDs, accounting for 25% of the 15 million new cases of sexually transmitted diseases in the United States annually. As such, sexually active adolescents should be screened annually for STDs, including:

- Screening for gonorrhea and chlamydia
- Serologic testing for syphilis if they have:
 - o History of prior STDs
 - o Multiple sexual partners
 - o Exchanged sex for drugs or money
 - o Used illicit drugs
 - o Been admitted to jail or other detention facility
 - o Lived in an endemic area
- Evaluation for human papillomavirus by visual inspection and Pap test

H. Human immunodeficiency virus

All adolescents should be evaluated for HIV risk status. Those found to be at risk should be offered HIV testing according to the following recommendations:

1. Adolescents are at high risk if they have any of the following characteristics:
 - Multiple sexual partners
 - High-risk partner, e.g., HIV positive, injectable drug user, bisexual, or has had more than one sexual partner
 - Prior STDs
 - Exchanges sex for drugs or money
 - Long-term residence or birth in an area with high prevalence of HIV infection
 - History of blood transfusion prior to 1985
 - Use of intravenous drugs
2. Testing of non-pregnant adolescents should be performed only after informed consent is obtained, consistent with state legal requirements.
3. Testing should be performed only in conjunction with both pretest and posttest counseling.
4. The frequency of screening for HIV infection should be determined by risk factors.
5. Universal HIV testing, with patient notification, should be a routine component of prenatal care for all pregnant adolescents. If the adolescent declines testing, this should be noted in the medical record.

I. Human Papillomavirus

All sexually active adolescents and all patients 18 years of age or older should be screened annually for human papillomavirus with a Pap test. Abnormal cervical cytology should be evaluated.

J. Depression

All adolescents should be asked annually about behaviors or emotions that indicate recurrent or severe depression and risk of suicide. Feelings of sadness should not be dismissed as mere moodiness in this patient population. Situational losses, relationship and school problems, parental loss, and parental conflicts may lead to depression. Recognition of depression and subsequent intervention can reduce suicidal behaviors in adolescent women.

Recommendations for screening for depression are as follows:

- Screening for depression or suicidal risk should be performed on adolescents who exhibit

cumulative risk as determined by declining school grades, chronic sadness, family dysfunction, problems with sexual orientation, physical or sexual abuse, alcohol or other drug use, family history of suicide, previous suicide attempt, and suicidal plans.

- If suicidal risk is suspected, adolescents should be evaluated immediately and, based on degree of risk, referred to a mental health professional or hospitalized.
- Non-suicidal adolescents with symptoms of severe or recurrent depression should be assessed and, if necessary, referred to a mental health professional for treatment.

K. Abuse

According to the Commonwealth Fund's Commission on Women's Health, 26% of adolescent girls in grades 9-12 report experiencing physical or sexual abuse, including date rape. Given this high incidence, all adolescents should be asked annually about a history of abuse, including emotional, physical, and sexual abuse.

Following are screening recommendations:

- If abuse is suspected, adolescents should be questioned regarding the circumstances surrounding the abuse; assessed for physical, emotional, and psychosocial consequences; and screened for involvement in risky health behaviors.
- Health providers should be aware of local laws requiring breach of confidentiality and reporting of abuse to appropriate state officials.
- Adolescents who report emotional or psychosocial sequelae from abuse should be referred to a mental health professional for evaluation and treatment.

L. School Performance

All adolescents should be assessed annually for learning or school-related problems. Adolescents with a history of truancy, repeated absences, or poor or declining performance should be assessed or referred to other professionals to screen for the presence of conditions that could interfere with school success. These include learning disabilities, attention deficit hyperactivity disorder, medical problems, abuse, family dysfunction, mental disorder, add alcohol or other drug use. This assessment and the subsequent management should be coordinated with school personnel, the primary medical care provider (if different from the obstetrician-gynecologist), and the adolescent's parents or caregivers.

M. Tuberculosis

Adolescents should be evaluated for tuberculosis risk status, Adolescents should receive a tuberculin skin test if they:

- Have been exposed to active tuberculosis
- Have lived in a homeless shelter, been incarcerated, or lived in another long-term care facility
- Have lived in or come from an area with high prevalence of tuberculosis, or lived with persons known or suspected to have tuberculosis
- Are currently working in a health care setting
- Are HIV positive
- Are medically underserved or low-income status
- Have a history of alcoholism
- Have medical risk factors known to increase the risk of disease if infected

The frequency of testing depends upon the individual adolescent's risk factors. Adolescents with a positive tuberculin test should be treated according the treatment guidelines put forth jointly by the Centers for Disease Control and Prevention and the American Thoracic Society.

V. Immunization

National immunization policies have changed in response to the development of a vaccination against Hepatitis B virus and the resurgence of measles and rubella among adolescent and adult populations. All adolescents should receive prophylactic immunizations according to the guidelines established by the federally convened Advisory Committee on Immunization Practices.

Physicians should determine the number and type of previous vaccinations to assess the immunization needs of the adolescent. Ideally, all vaccinations should be administered at the scheduled 11-12-year visit. In many instances, however, it will be necessary for physicians to administer vaccines to those who have fallen behind the recommended schedule, or who were older than 11-12 years when the recommendations were formulated. Prior to administering immunizations, physicians should ensure that, if required, the necessary parental consent has been obtained. Following are recommendations for determining what immunizations are needed:

- Adolescents should receive a bivalent tetanus- diphtheria vaccine booster at the 11- 12-year visit if not previously vaccinated within 5 years. With the exception of the tetanus-diphtheria booster at 11-12 years, routine boosters should be administered every 10 years.
- Adolescents should receive a second dose of measles, mumps, and rubella vaccine at age 11-12 years, unless there is documentation of two vaccinations earlier during childhood. Measles, mumps, and rubella vaccine should not be administered to pregnant adolescents.
- Hepatitis B immunization is administered in three parts and generally is provided to infants. Older children should be assessed and if unvaccinated, should receive immunization at 11-12 years of age. The immunization status of older adolescents should also be assessed and the vaccine administered, if necessary.
- Hepatitis A vaccination should be given to adolescents who are traveling to or living in countries with high or intermediate endemicity of hepatitis A virus, live in communities with high endemic rates of hepatitis A virus, have chronic liver disease, or are injecting drug users.
- Varicella should be administered at the 11-12 year visit to all unvaccinated persons or those lacking a reliable history of chickenpox. Susceptible persons 13 years of age or older should receive two doses, at least 1 month apart.

VI. Summary

Although most adolescents enjoy good health, many of their behaviors put them at risk for negative health outcomes. Consequently, a fundamental change in the provision of health care services is required. Increasingly, services must be directed at primary and secondary prevention. As such, physicians should respond by making preventive services a greater component of their clinical practice. The approach outlined previously can help in this transition and can ensure that adolescents receive the services their health status demands.