The art of gynecological history taking & Examination

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Why history taking is important?

Direct Observations Before Speaking to the Patient (Nonverbal Clues)

- Meeting and greeting a patient.
- Differing cultural backgrounds and belief systems.
- The general demeanor of the patient should be evaluated.
- Many new patients are apprehensive about meeting a new physician and the pelvic examination. This apprehension may create barriers to an open and positive first encounter.
- By observing nonverbal clues, such as eye contact, posture, facial expressions, or tone of voice, the physician can determine the appropriate approach for conducting the interview.
- The act of greeting the woman by name, making eye contact, and shaking hands is a formal but friendly start to the visit.
- During the interview the physician should face the patient with direct eye contact and acknowledge important points of the history.
- Now that electronic medical records (EMRs) are almost universally utilized, the ability to sit and just listen to the patient and provide that direct eye contact can be challenging, as providers are often documenting while the patient is sharing her story.

Effective communication skills

- Four qualities have been recognized as potentially important in caring communication skills:
  - comfort,
  - acceptance,
  - responsiveness,
  - empathy.

Components of Effective Physician Communication

- Be culturally sensitive.
- Establish rapport.
- Listen and respond to the woman's concerns (empathy).
- Be nonjudgmental.
- Include both verbal and nonverbal communication.
- Engage the woman in discussion and treatment options (partnership).
- Convey comfort in discussing sensitive topics.
- Abandon stereotypes.
- Check for understanding of your explanations.
- Show support by helping the woman to overcome barriers to care and compliance with treatment.

At the beginning

- Introduce yourself to the patient and obtain verbal consent.
- Confirm patient identity, name, age, parity, ethnic origin and work
- Make your language easy and don’t use medical jargon

Importance of age

- **Prepubertal-**Although rare but some young girls may come with bleeding masses related to reproductive organs foreign bodies and child abuse .
- **Adolescent** –mainly pubertal abnormalities, menstrual disorders such as oligomenorrhea dysmenorrhea, dysuria, dyschezia and abnormal uterine bleeding, hirsutism, acne, obesity, vaginal discharge and sexual assault.
- **Reproductive age** women from 15-45- these women may come complaining of abnormal uterine bleeding infertility issue pelvic pains, vaginal discharge mass ovarian, uterine or cervical lesions.
- **Menopausal woman-** usually either for menopausal syndrome just like hot flashes brightness you trying prolapse you trying messes where in masses and post menopausal bleeding .
- Please consider pregnancy in any woman coming with bleeding in her productive age

History outlines

I. Observation—nonverbal clues

II. Chief complaint

III. History of gynecologic problem(s)

- A. Menstrual history—last menstrual period, previous menstrual period
- B. Pregnancy history
- C. Vaginal and pelvic infections
- D. Gynecologic surgical procedures
- E. Urologic history
- F. Pelvic pain
- G. Vaginal bleeding
- H. Sexual status
- I. Contraceptive status

IV. Significant health problems

A. Systemic illnesses, including bleeding problems

B. Surgical procedures

C. Other hospitalizations

V. Medications, habits, and allergies

A. Medications taken

B. Medication and other allergies

C. Smoking history

D. Alcohol usage

E. Illicit drug usage

History outlines

VI. Family history

A. Illnesses and causes of death of first-order relatives

B. Congenital malformations, mental retardation, and reproductive loss

VII. Occupational and avocational history

VIII. Social history

IX. Review of systems

A. Constitutional—such as fever, fatigue

B. Head, eyes, ears, nose, mouth, throat

C. Cardiovascular—such as chest pain

D. Respiratory—such as cough or shortness of breath

E. Gastrointestinal—such as constipation, bloating, diarrhea, abdominal pain

F. Genitourinary—such as incontinence, urinary frequency or urgency

G. Musculoskeletal—such as back pain

H. Skin

I. Neurologic

J. Psychiatric—such as sadness, feeling down or anxious; a short depression screening inventory can be administered; a frequently utilized inventory is the Patient Health Questionnaire 9

K. Endocrine—such as significant weight gain or loss

L. Hematologic—easy bleeding from gums or nose

M. Allergic/immunologic

X. Physical abuse

A. Sexual abuse—incest, rape, sexual touching

Essence of the Gynecologic History

- **Chief Complaint**
- The patient should be encouraged to tell the physician why she has sought help.
- The chief complaint is a concise statement describing the woman's problem ***in her words***.
- Questions such as "What is the nature of the problem that brought you to me?" or "How may I help you?" are good ways to begin.

Common menstrual bleeding abnormalities

- They may be heavy prolonged with clots
- you need to establish how many days if there are more than 8 it's prolonged if she changed many pads in one day, fully socked associated with the clots-heavy.
- Oligomenorrhea-If her period occurring more than 35 days.
- Amenorrhea- absence of periods more than 3 cycles in oligomenorrheic, and 6 months in regular cycle women

Menstrual history

- In which the age of menarche, duration of each monthly cycle, number of days during which menses occurs, and regularity of the menstrual cycles should be noted. Presence of clots & Use of pads
- The dates of the last menstrual period should be obtained.
- In addition, the characteristics of the menstrual flow, including the color, the amount of flow, and accompanying symptoms, such as cramping, nausea, headache, or diarrhea, should be noted.
- In general, menstruation that occurs monthly (range 21 to 35 days), lasts 4 to 7 days, is bright red, and is often accompanied by cramping on the day preceding and the first day of the period are all characteristics of an ovulatory cycle.
- Menstruation that is irregular, often dark in color, painless, and frequently short or very long may indicate lack of ovulation.
- Often adolescents or premenopausal women have anovulatory cycles with resultant irregular menstruation.
- Any vaginal bleeding not related to menses (intermenstrual bleeding) should be noted, as well as its relationship to the menstrual cycle and to other events, such as coitus (postcoital bleeding), the use of tampons, or the use of a contraceptive device.
- For the postmenopausal woman, the age at last menses, history of hormone replacement therapy, and any postmenopausal bleeding should be noted.

Causes of post-coital bleeding

Causes of post-coital bleeding

Vaginal	Vaginal cancer
	Vaginitis
Cervical	Cervical ectropion
	Cervical polyp
	Cervical cancer
	Infection
Uterine	Endometrial polyp
Other	Trauma

Causes of intermenstrual bleeding

Physiological	Ovulation
Vaginal	Adenosis
	Vaginal cancer
Cervical	Cervical polyp
	Cervical ectropion
	Cervical cancer
	Infection (chlamydia, gonorrhoea)
	Condylomata
Uterine	Endometrial polyp
	Fibroids
	Endometritis
	Adenomyosis
	Endometrial cancer
	Caesarean scar defect
	Malpositioned IUCD
Ovarian	Hormone secreting tumours
Hormonal	Hormonal contraceptive use
	Poor compliance with hormonal contraceptive
	Perimenopausal hormonal changes
Other	Drug use (Tamoxifen, anticoagulants)
	Drug interaction with hormonal contraceptives

Pelvic pain

- Dysmenorrhea- pain during periods
- Dyspareunia- pain during intercourse can be superficial or deep
- Dysuria- pain during urination
- Dyschesia-pain during bowel motion

Vaginal discharge

- This may be normal and variable during the menstrual cycle. Prior to ovulation, it is clear and abundant, and stretches like egg white; after ovulation, it is thicker, does not stretch and is less abundant. Abnormal vaginal discharge occurs with infection. Ask about:
- consistency
- colour
- odour
- associated itch, pain or dysuria.
- Past episodes
- Ask about partner STI history

Vaginal discharge

- **The most common non-sexually transmitted infection**
- **Candida** gives a thick, white, curdy discharge often associated with marked vulval itching.
- **Bacterial vaginosis** is a common, non-sexually acquired infection, usually caused by Gardnerella vaginalis , producing a watery, fishy-smelling discharge. The pH of normal vaginal secretions is usually < 4.5 but in bacterial vaginosis it is > 5.
- **Sexually transmitted infections (STIs)**
- **Chlamydia & Gonorrhea** usually do not cause symptoms. When symptoms do occur, they may show up between a few days and several weeks after infection.
  - A yellow discharge from the vagina or urethra
  - Painful or frequent urination
  - Vaginal bleeding between periods
  - Rectal bleeding, discharge, or pain
- **Trichomoniasis** causes symptoms, they may appear within five to 28 days of exposure and range from mild irritation to severe inflammation. Signs and symptoms may include:
  - Clear, white, greenish or yellowish vaginal discharge
  - Discharge from the penis
  - Strong vaginal odor
  - Vaginal itching or irritation
  - Itching or irritation inside the penis
  - Pain during sexual intercourse
  - Painful urination

Taking a sexual history

- Are you currently in a sexually active?
- How long have you been with your partner?
- Do you use barrier contraception – sometimes, always or never?
- Have you ever had a sexually transmitted infection?
- Are you concerned about any sexual issues?
- Frequency of intercourse
- Presence of libido, orgasm?
- Presence of Female Sexual Dysfunction?
- Partner's erectile function/dysfunction?
- Presence of dyspareunia-deep/superficial?
- Postcoital bleeding?

Some examples of direct questions around the menstrual history, together with some points requiring clarification

- How old were you when your periods first started? (Menarche.)
- What was the first day of your last normal menstrual period? (Patients may recall the last day of the period which is not contributory. Whether the period was normal or not is important, as sometimes vaginal blood loss may be that associated with an abnormal pregnancy.)
- How often do your periods come?
- How many days are there from the first day of one period to the first day of the next? (It could be that the cycle is irregular; many women keep a diary of their menstrual periods and it is often helpful to see this.)
- For how many days do you bleed?
- How many heavy days are there? (With these two questions you are trying to gauge the level of menstrual loss, so some estimate of the volume of flow is required.)

Some examples of direct questions around the menstrual history, together with some points requiring clarification

- Do you use tampons, pads or both? How often do you have to change them? (The use of both tampons and pads together is termed ‘double protection’ and is strongly indicative of menorrhagia.)
- Do you pass blood clots, and if so how large are they? (The second part of this question is difficult to answer without a frame of reference, and comparison to coins of different denominations can be helpful.)
- Do you ever bleed through your clothes? Is the bleeding like a running tap? (This is called ‘flooding’.)
- Does the bleeding interfere with your usual daily activities, e.g. do you have to take time off work? (This is a very important question as it helps to judge the impact of the bleeding problem.)
- Are your periods painful? (Some assessment of the degree of pain is necessary here, e.g. is medication used and, if so, what and how much? Does the pain stop you from carrying out your normal activities?)
- Do you have any other symptoms with your periods? (This is an enquiry about premenstrual syndrome, in which a variety of symptoms can aggregate and then disappear as menstrual flow starts.)

Several other questions are required in order to check for bleeding problems not connected to periods

- Do you have bleeding between your periods? (If so, how much and when does it occur?)
- Do you have any bleeding after sexual intercourse (Post-coital bleeding)? (If so, ask for an estimate of how frequently this loss occurs and how heavy it is.)
- What form of contraception are you using? (In the last two questions, it is first necessary to establish whether the patient is in a sexual relationship; this requires additional tact.

The pattern of menstruation may be influenced by use of various contraceptive methods including the combined oestrogen/progestogen pill (COC), the (POP), injectable progestogens, various intrauterine contraceptive devices and newer progestogen-containing rings placed in the vagina.)

Symptoms of pelvic pain

- Symptoms of pelvic pain or discomfort should be discussed fully.
- Six common questions should be asked about the pain:
- location; timing; quality, such as throbbing, burning, colicky; radiation to other body areas; intensity on a scale of 1 to 10 (VAS score-visual analogue Score), with 10 being the worse pain imaginable; and duration of symptoms.
- Additional questions about what causes the pain to worsen or subside; the context of the pain symptoms; and associated triggers, signs, and symptoms may be helpful. The pain should be described, noting the presence or absence of a relationship to the menstrual cycle and its association with other events, such as coitus or bleeding and bladder and bowel symptoms.

Characteristics of pelvic pain (SOCRAT)

	Uterine pain	Ovarian pain	Adhesions or pelvic infection	Endometriosis
S ite	Midline	Left or right iliac fossa	Generalised lower abdomen; more on one side	Variable
O nset	Builds up before period	Sudden, intermittent	Builds up, acute on chronic	Builds up, sudden
C haracter	Cramping	Gripping	Shooting, gripping	Shooting, cramping
R adiation	Lower back and upper thighs	Groin; if free fluid, to shoulder	back	Lower back and upper thighs
A ssociated symptoms	Bleeding from vagina	Known cyst, pregnancy, irregular cycle	Discharge, fever, past surgery	Infertility. Bloating, alternating cons/diarrhea
T iming	With menstruation	May be cyclical	Acute, may be cyclical	Builds up before & during period
E xacerbating factors	–	Positional	Movement, examination	Intercourse, cyclical, stress
S everity	Variable in spasms	Intense	Intense in waves	VAS SCORE

History of the Present Illness (HPI)

- The patient should be able to present the problem as she sees it, in her own words, and should be interrupted only for specific clarification of points or to offer direction if she digresses too far.
- When the patient has completed the history of her current problem, pertinent open-ended questions should be asked with respect to specific points.
- This process allows the physician to develop a more detailed database.
- Directed questions may be asked where pertinent to clarify points.
- Encourage the patient to tell her story as she sees it rather than to react with short answers to specific questions.
- Under the latter circumstance, the physician may get the answers he or she is looking for, but they may not be accurate answers.
- When the HPI is documented in the medical record, it represents a chronologic history of the current concerns.

Previous pregnancies.

- The woman should be asked specifically to list all pregnancies, including chemical pregnancies, all miscarriages (spontaneous and induced), molar and ectopic pregnancies.
- For deliveries, the following information should be obtained: year of birth, gestational age at delivery, the type of delivery, infant birth weight, and any complications that may have occurred.
- For all other pregnancies, the circumstances under which they took place, the method by which they were concluded (dilation and curettage [D&C], methotrexate, etc.), and any complications should be obtained.

Direct questions that may help inform the obstetric history

- How many times have you been pregnant? (Be aware that some patients may not indicate that they have had terminations of pregnancy.)
- What was the weight of the heaviest and the lightest baby?
- How old were you when you had your first pregnancy?
- How old are the children now? or
- How old is the youngest and how old is the oldest?
- How old would he be if he had survived?
- Did you have any difficulty getting pregnant?

General Health History

- The woman should be asked to list any significant health problems that she has had during her lifetime, including all hospitalizations and operative procedures.
- Medications taken and reasons for doing so should be noted, as should allergic responses to medications.
- A history of smoking should be obtained in detail, including amount, length of time she has smoked, and attempts at quitting smoking. She should be questioned about the use of illicit drugs, including heroin, methamphetamines, cocaine, and prescription drug abuse with narcotics.
- Her use of alcohol should be detailed carefully, including the number of drinks per day and any history of binge drinking or previous therapy for alcoholism.

Past Gyn history

- Pap smear screening history, including the date of the last Pap smear, the frequency of screening, and any abnormal tests and the treatment.
- The woman's contraceptive history should be investigated, including methods used, length of time they have been used, effectiveness, and any complications that may have arisen.
- Screening History- Rubella, Cervical ca prevention- The patient's human papilloma virus (HPV) vaccination status should be determined.
- All instances of gynecologic surgical procedures should be noted,
- A complete sexual history should be obtained and specific problems should be evaluated. The history should include whether the patient is currently sexually active or has been in the past. Patients should be asked if they have one or more current partners and if they have sex with men, women, or both. The provider should also inquire about any sexual dysfunction such as dyspareunia or anorgasmia.

Family History

- A detailed family history of first- and second-degree relatives (parents, siblings, children, aunts, uncles, and grandparents) should be taken and a family tree constructed if relevant.
- Serious illnesses or causes of death for each individual should be noted. If the woman desires fertility now or in the future, an inquiry should be made about any congenital malformations, mental retardation, or pregnancy loss in either the woman’s or her spouse’s family. Such information may offer clues to hereditarily determined causes of reproductive problems.

Occupational and Social History

- The woman should be asked to detail her occupation. A nonjudgmental way to approach this could be to ask if she is currently working outside of the home. It is very important to determine if she is currently exercising, what type of activity she engages in, and the frequency of exercise.

- Additional information that may be relevant include hobbies and other avocations that may affect health or reproductive capacity, where and with whom the woman lives, other individuals in the household, areas of the world where the woman has lived or traveled, or unusual experiences that may affect her health.

Safety Issues

- She should be asked about the use of seat belts and helmets (if she rides a bicycle, motorcycle, or horse).
- She should be asked whether there are firearms in her household and, if so, whether appropriate safety precautions are taken.
- A question about intimate partner violence is appropriate and can be asked in a nonthreatening manner, such as “Has anyone in your household threatened or physically hurt you?”
- Sexual violence is a widespread problem, and as more is being learned about prevention, providers should be knowledgeable about resources

Nutritional and Dietary Assessment

- It is important to inquire about dietary choices that our patients make.
- Assessment of folic acid is important in reproductive-aged women.
- Asking about fruits and vegetables as well as calcium-containing foods should be standard.
- Vegetarians and vegans may need additional discussion about adequate protein and vitamin/mineral intake.
- A referral to a certified nutritionist may be a valuable addition to routine preventive health care.

Dysmenorrhea history checklist

1. Menstrual history
2. Relationship between menarche and onset of dysmenorrhea
3. Timing of pain in relation to menses and amount of menstrual flow
4. Characterization, severity, chronology, and resulting disability
5. Sexual history including inquiry about sexual abuse
6. Inquiry about chronic pain syndromes and medical conditions
7. Presence of symptoms of depression, anxiety, or other psychiatric disorders
8. Previous treatment including dose, duration of use, side effects, and response

Post menopause or perimenopause women

If the patient is post- or perimenopausal, the history taking should reflect this.

- Are you still having periods? or
- When did you have your last period?
- Menopausal syndrome-hot flushes….
- Has there been any bleeding since your last period? (This relates to a definition of postmenopausal bleeding – generally defined as bleeding 6 months after the last period, unless the patient is taking hormone replacement therapy, in which case it is important to establish which type.
- Exclusion of organic pathology is mandatory in this situation.)

Vaginal discharge

- Even if this is not the presenting symptom, it should be routinely enquired about.
- If there is a troublesome discharge, enquire about its colour, smell, amount, presence of blood, whether there is an associated vulval itch and, if so, if there are other sites of itching.
- In women with an abnormal vaginal discharge, questions relating to sexually transmitted disease naturally follow but can be difficult to pose.
- If the patient is in a sexual relationship, ask about symptoms in her partner(s) and whether either (any) of them are aware of the presence of warts.

Questions to ask if a prolapse is suspected

- Do you have a feeling of something coming down?
- Does the feeling go away overnight or when you lie down? (Symptomatic prolapse is gravity dependent except in the most severe cases.)
- Are there occasions when you don't make it to the toilet in time?
- Do you leak urine if you cough or sneeze?
- When you pass urine, do you feel you have completely emptied your bladder?
- When you are passing urine, can you squeeze hard enough to stop the flow? (Arresting flow mid stream is a good test of the strength of the pelvic floor.)
- How often do you get up at night to pass urine?
- Have you ever seen blood in your urine?

Special questions in infertility cases

- Duration
- Past history- medical and surgical, tests
- Sexually active or not
- Frequency
- Desire
- Pain
- Discharge
- Family history of infertility
- STI history
- Husband erectile function, past history- medical and surgical, tests

Special questions in a case with abdominal pain relevant o gynecological condition

- LMP
- Onset
- Nature
- Location
- Radiation
- Intensity- VAS-1-10
- Associated factors- vaginal discharge, bleeding, nausea and vomiting
- Alleviating and triggering factors
- History of nay uterine or ovarian masses
- Procedures
- Tests

A case with abdomino-pelvic mass

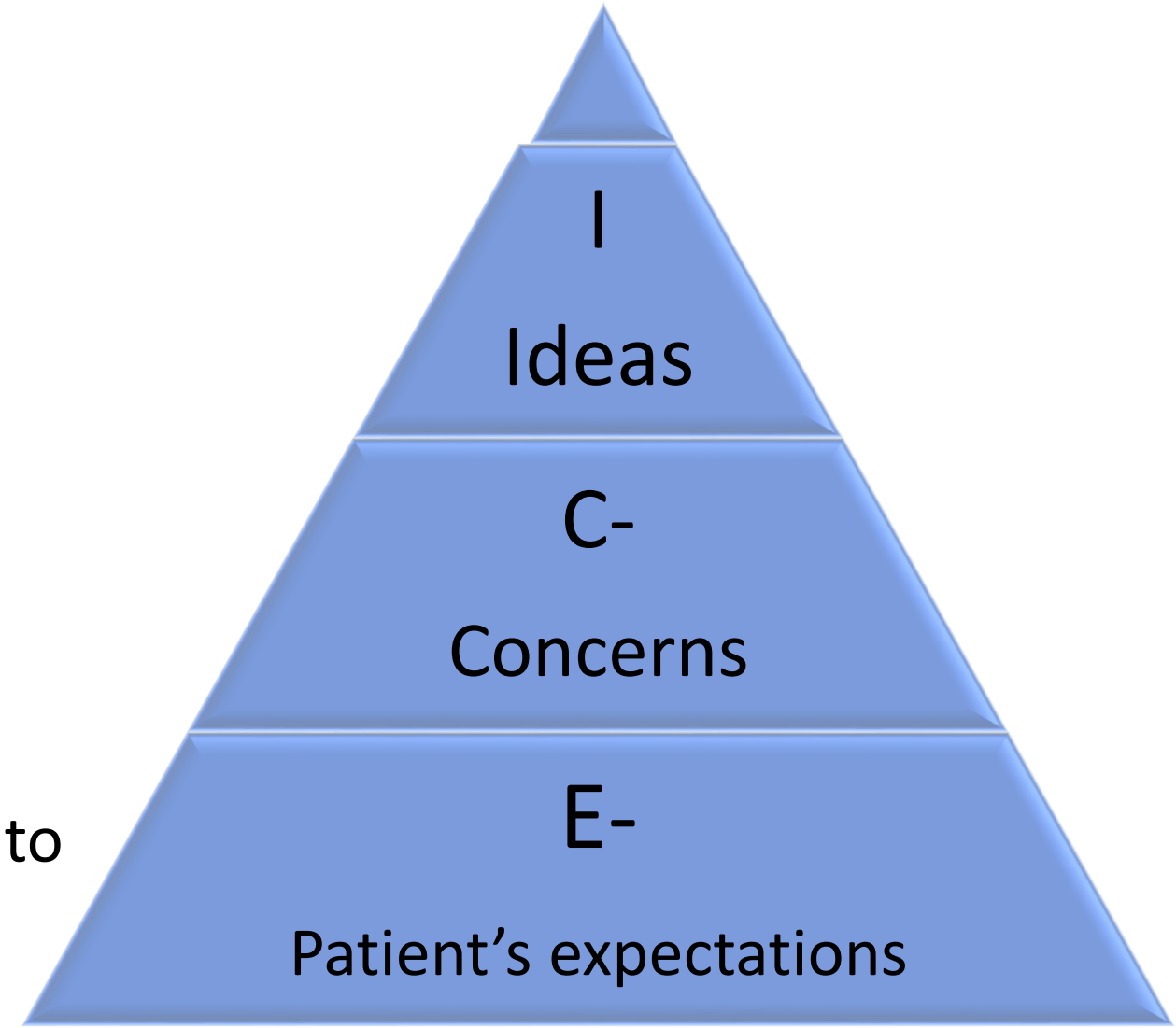
- Onset
- Course over time- increase, how rapid?
- Tenderness
- Associated factors- bleeding, pain, frequency in micturition.
- Other signs- hair growth, loss of weight, cardio- respiratory symptoms
- History of masses
- Past procedures

Direct questions for patients presenting with pain on sexual intercourse

- How severe is the pain – does sex have to stop?
- Does it happen every time you have sex or only on some occasions? (If intermittent, ask how often this happens.)
- Can you say if the pain is superficial (near the outside) or deep on the inside? (Typical causes of deep dyspareunia include endometriosis and chronic pelvic inflammatory disease.)
- Do you have any other pains in the pelvic region other than the one brought on by sexual activity?
- Is there any bleeding during or after penetrative sex?

Summary

- Summarize the history & confirm
- Use ICE
  - **I- Ideas**
  - **C- Concerns**
  - **E- expectations of patient**
- Thank the patient & proceed to examination



THANK YOU

QUESTIONS???

The gyn Examination

Indications

- Sexually transmitted infection testing or screening
- Screening exams by primary care physicians and gynecologists
- Pain
- Discharge
- Pregnancy or postpartum
- Infection
- Itching
- Before Pap Smear or HVS
- Swelling
- Bleeding
- Menstrual abnormalities
- Sexual development abnormalities
- Sexual or physical trauma
- Neurological conditions
- Incontinence
- Pelvic floor disorders
- Insertion or removing an IUD

Indications for the first gyn examination

- Age 21 yr for initial Pap test
- Unexplained menstrual
- irregularities, including
- pubertal aberrations (especially delayed puberty)
- Severe dysmenorrhea
- Unexplained abdominal or pelvic pain
- Unexplained dysuria
- Abnormal vaginal discharge
- Placement of intrauterine device
- Removal of foreign body
- Inability to place tampons

Equipment

- The pelvic examination is typically performed on a flat surface or examining table, preferably one with foot supports.
- Gloves
- Lubricant
- Paper towels
- Specula come in a variety of sizes and types. Metal specula are not disposable and need sterilization between each use. Plastic specula are disposable and individually used.
- The Cusco speculum is the most commonly used speculum; it has 2 handles and a fixed base. The handles can either be opened like a duckbill or spread further apart with the mechanism on the handle.
- The Pederson speculum is with narrower blades for pediatric patients or to accommodate a narrower vagina.
- Many speculums are designed with a light source. If the speculum is not designed with a light source, ensure proper lighting with an adjustable lamp.
- Simple room lighting will not be adequate for the examination.

Personnel

- Many gynecological exams include the presence of a chaperone.
- Male providers almost always have a female chaperone present and female providers frequently feel comfortable without one.
- It is recommended that a patient be asked whether she would prefer to have a chaperone present and her request be obliged when preferred.
- When possible, it is good practice to have a chaperone present both for the patient's and provider's security, although there is little evidence suggesting that the presence of a chaperone reduces litigation

Preparation-1

- Wash hands
- Introduce yourself
- Confirm patient details – name / DOB
- Ask if the patient thinks they may be pregnant
- Informed consent should be obtained.
- Every part of the exam should be explained prior to it being done (What you are going to do? Why? How? and expectations-pain, discomfort..etc).
- The patient should be undressed from the waist down and covered with a sheet to maintain modesty.
- The patient should be uncovered for only as much time as is necessary for the exam.
- Until the patient is properly positioned, she should remain draped.

Preparation-2

- Instruct the patient to lie on her back on the bed in the dorsal lithotomy position.
- This is achieved by placing her feet in the foot supports and scooting herself down in the bed until her thighs are roughly perpendicular to the ground or further bent toward the abdomen. The patient's buttocks should be at the edge of the bed or slightly farther to provide for better mobility of the speculum and better visualization.
- If a table with foot supports is unavailable, the pelvic exam can be done by placing the patient's hips on top of a padded flipped washbasin or bedpan with the patient's legs bent toward her chest or placed in frog-leg position with the bottoms of her feet together.

Abdominal examination:

- **An abdominal examination should always be performed before moving onto vaginal examination- masses, tenderness.**
- This may be less thorough than a full abdominal examination but should at least include inspection and palpation of the abdomen.
- You may ask if the patient would like to empty their bladder before the examination.

Abdominal examination:

- Inspection
  - The examiner assesses for any obvious distention, masses, hernias, or scars.
- Auscultation
  - The examiner listens to all 4 quadrants for hypoactive, hyperactive, or normoactive bowel sounds.
- Palpation
  - Superficial and deep palpation is performed to assess for any focal tenderness, trigger points, scar tissue, or masses. The examiner then palpates the intraabdominal muscles and their insertions. Palpation of the iliacus muscle and iliopsoas muscle is also performed.

Examples of questions

- “I need you to go behind the curtain and remove your underwear, then please could you get onto the bed. You can cover yourself with the sheet provided.”
- "لو سمحت جهزي نفسك للفحص وراء الستارة بخلع الملابس الداخلية. والرجاء الاستلقاء على سرير الفحص وتغطية نفسك بالملاءة الموجودة"

- “Bring your heels towards your bottom and then let your knees fall to the sides.”
- "لو سمحت, أجلبي كعبيك نحو الأسفل ومن ثم انزلي ركبتيك على الجانبين "

Pelvic examination

- Inspect the vulva (next slide)
- Inspect for evidence of vaginal prolapse (a bulge visible protruding from the vagina).
- Ask the patient to cough as you inspect can exacerbate the lump and help confirm the presence of prolapse.

Vulvar inspection

a) Fusion of the labia majora and minora should be noted in conditions such as lichen sclerosis.

b) Examination of the mons includes noting hair distribution, moles, swelling or tenderness, and male versus female pattern of hair growth.

c) Ulcers – e.g. genital herpes

d) Scars – previous surgery e.g. episiotomy

e) Abnormal discharge / bleeding

f) Atrophy – postmenopausal

g) Masses – e.g. Bartholin's cyst: Bartholin glands are in the most distal part of the vaginal opening, at approximately the 5 and 7 o'clock positions. The gland opening typically cannot be identified. A mass palpable in this region is typically a Bartholin cyst.

h) Varicosities – varicose veins: Vulvar varicosities should be palpated and noted, with comment as to location and extent of venous insufficiency. With the thumb on the perineum and the index finger in the vaginal opening, the labia can be palpated for lumps, tumors, pain, or lymphadenopathy.

i) Abnormal hair distribution

j) basic developmental assessment,

k) symmetry

l) growths such as external genital warts (EGW) or tumors

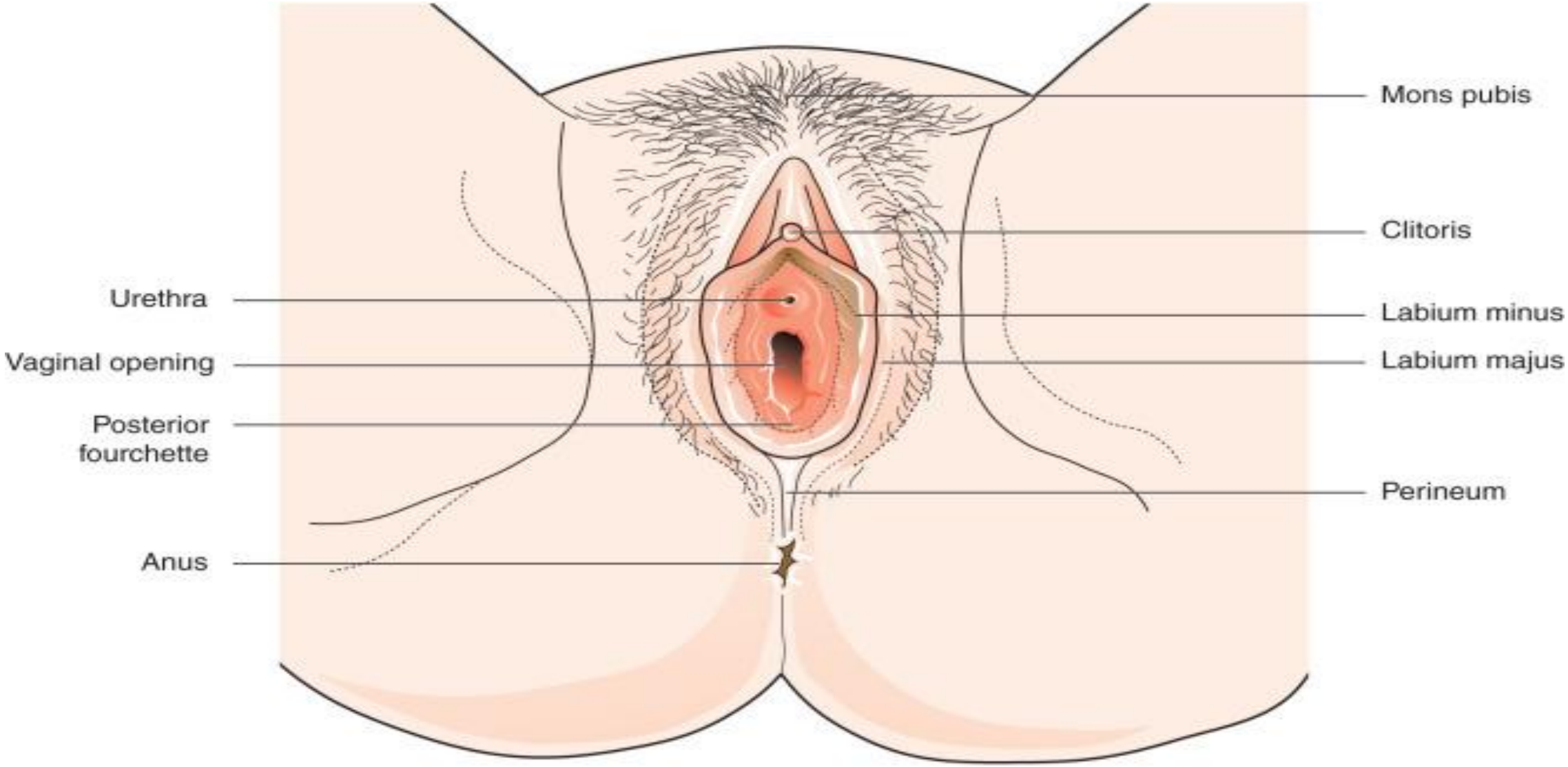
m) rashes,

n) piercings,

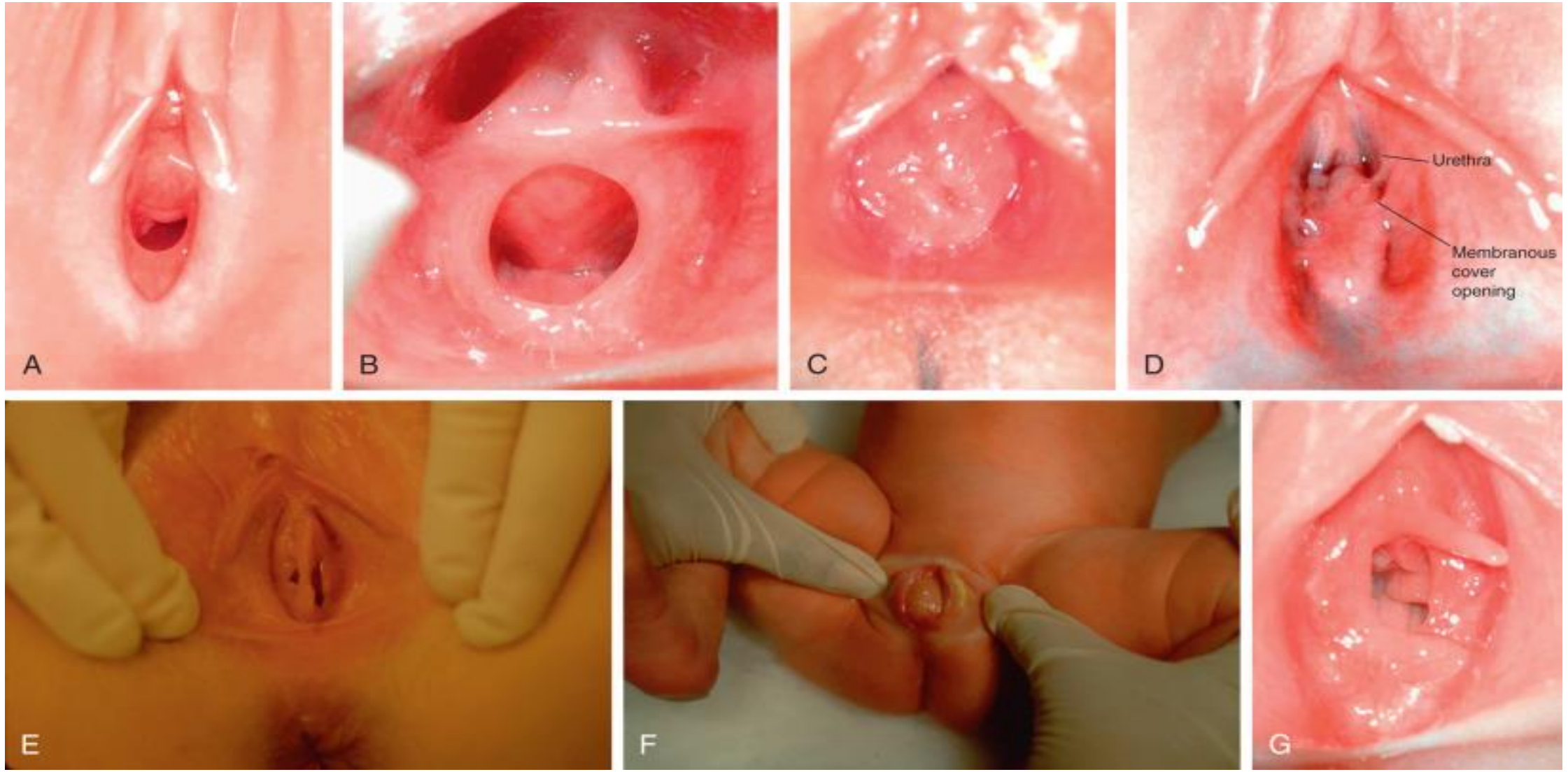
o) bruising, and discharge.

p) Some advocate noting general cleanliness.

q) Most examiners do not document tattoos or scars, but these could also be noted.


Mons pubis
Clitoris
Urethra
Labium minus
Vaginal opening
Labium majus
Posterior fourchette
Perineum
Anus


INSPECT
THE VULVA
• SCARS
• ERYTHEMA
• MASSES
• DISCHARGE / BLEEDING
• RASH / VESICLES

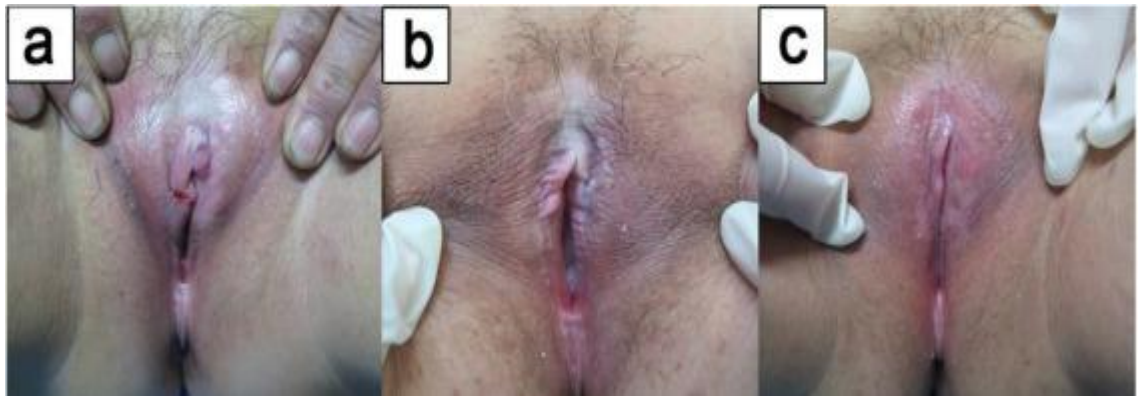


Types of hymens. A, Crescentic. B, Annular. C, Redundant. D, Microperforate. E, Septated. F, Imperforate. G, Hymeneal tags.

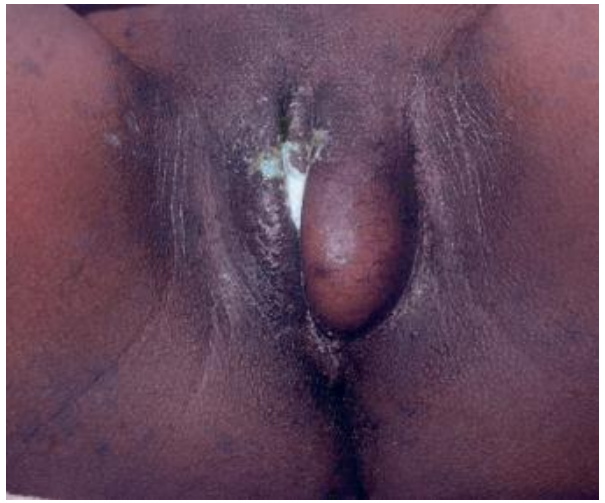
Inspection

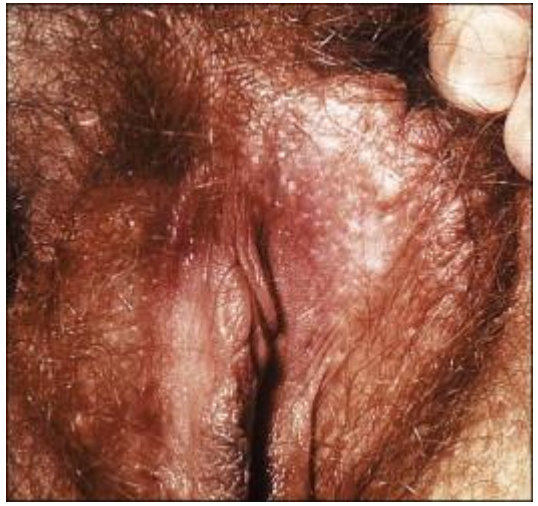
- Look at the perineum for any deficiency associated with childbirth; note abnormal hair distribution and clitoromegaly (associated with hyperandrogenism).
- Discharges
- Old scars
- Note any skin abnormalities, swellings of the vulva, such as the Bartholin's glands on each side of the fourchette

Vulvar lichen sclerosus



Bartholin's glands Abscess





Vulvar Cysts, Adenocarcinoma

Examples of how to ask patient's permission during pelvic & bimanual examination

- "I've been asked to carry out a bimanual examination. Do you understand what the examination involves?"-
- "لقد تم الطلب مني للقيام بالفحص الداخلي و الجَسُّ باليَدَين, هل تفهمين ما المقصود بهذا الفحص؟"
- "What the examination will involve is me using one hand to feel your tummy and the other hand to place two fingers into your vagina. This will allow me to assess the vagina, womb and ovaries. It shouldn't be painful, but it will feel a little uncomfortable. Let me know at any point if you would like me to stop."
- "الفحص يشمل استعمال يد واحدة لجس البطن واليد الاخرى لفحص المهبل باستخدام اصبعين. سيساعدني هذ الفحص لتقييم المهبل, الرحم و المبيضين. الفحص بشكل عام ليس مؤلم, ولكن قد يسبب بعض عدم الراحة. الرجاء اعلامي في اي لحظة اذا شعرت انه يجب ان انهي الفحص"

Examples of how to ask patient's permission during pelvic & bimanual examination

- Explain the need for a chaperone:
- "For this examination one of the female ward staff will be present acting as a chaperone."
- "لأجراء الفحص ستتواجد مرافقة من القسم"
- Gain verbal consent:
- "Does everything I've said make sense? Do you have any questions? Are you happy for me to perform the examination?"
- "هل كان شرحي واضحا وكافيا؟ هل لديك اي اسئلة؟ هل انت موافقة على عمل الفحص؟"

Vaginal examination

- Warn the patient you are going to examine the vagina and ask if they're still happy for you to do so.
- Entering the vagina

1. Lubricate gloved fingers

2. Carefully separate the labia using the thumb and index finger of your non-dominant hand

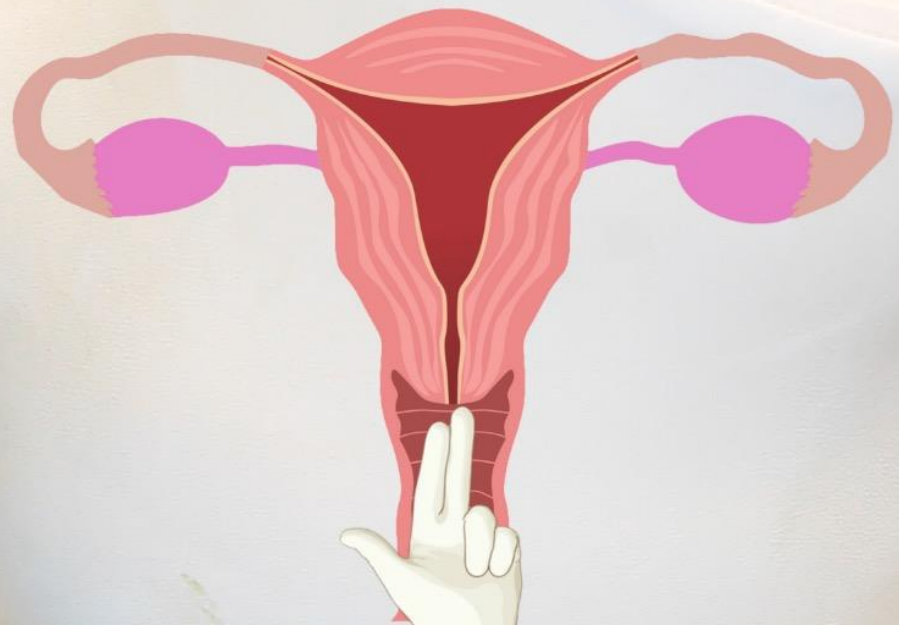
3. Gently insert the gloved index and middle finger of your dominant hand into the vagina

4. Enter the vagina with palm facing laterally and then rotate 90 degrees so that it faces upwards.

Vagina, Cervix and Fornices:

- Assess the vagina: Palpate the walls of the vagina for any irregularities or masses.
- Assess the cervix
    a. Position
    b. Consistency (hard/soft)
    c. Os (open/closed)
    d. Cervical excitation – severe pain on palpation of cervix – e.g. PID, ectopic
- Assess the fornices
- Gently palpate the fornices either side of the cervix for any masses.

ASSESS VAGINA & CERVIX (CERVICAL EXCITATION)



Uterus assessment during bimanual examination

1- Palpate the uterus:

a. Place your non-dominant hand 4cm above the pubis symphysis

b. Place your dominant hand's fingers into the posterior fornix

c. Push upwards with the internal fingers whilst simultaneously palpating the lower abdomen with your non-dominant hand. You should be able to feel the uterus between your hands. You should then assess the various characteristics of the uterus that are shown below.

2- Assess the uterus:

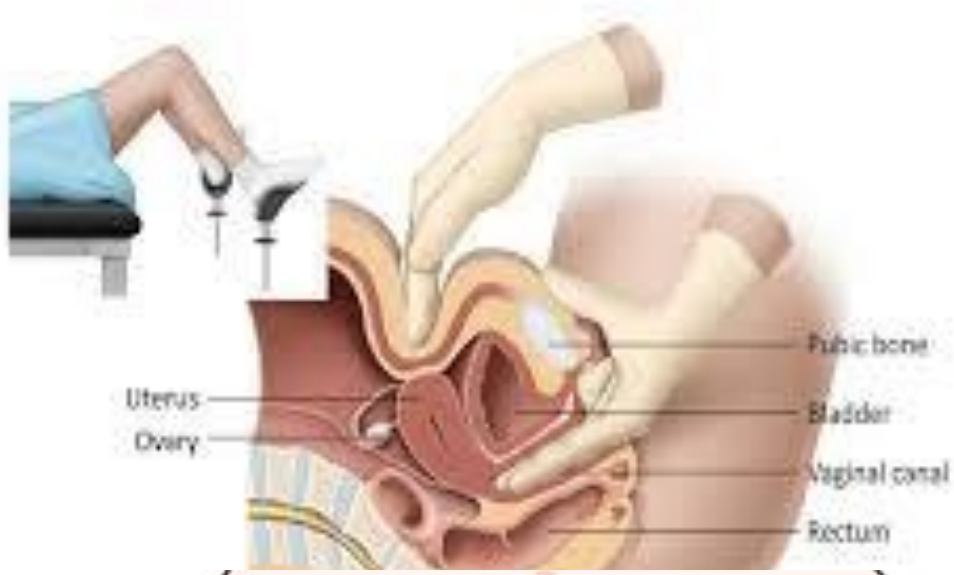
a. Size – approximately orange sized in an average female.

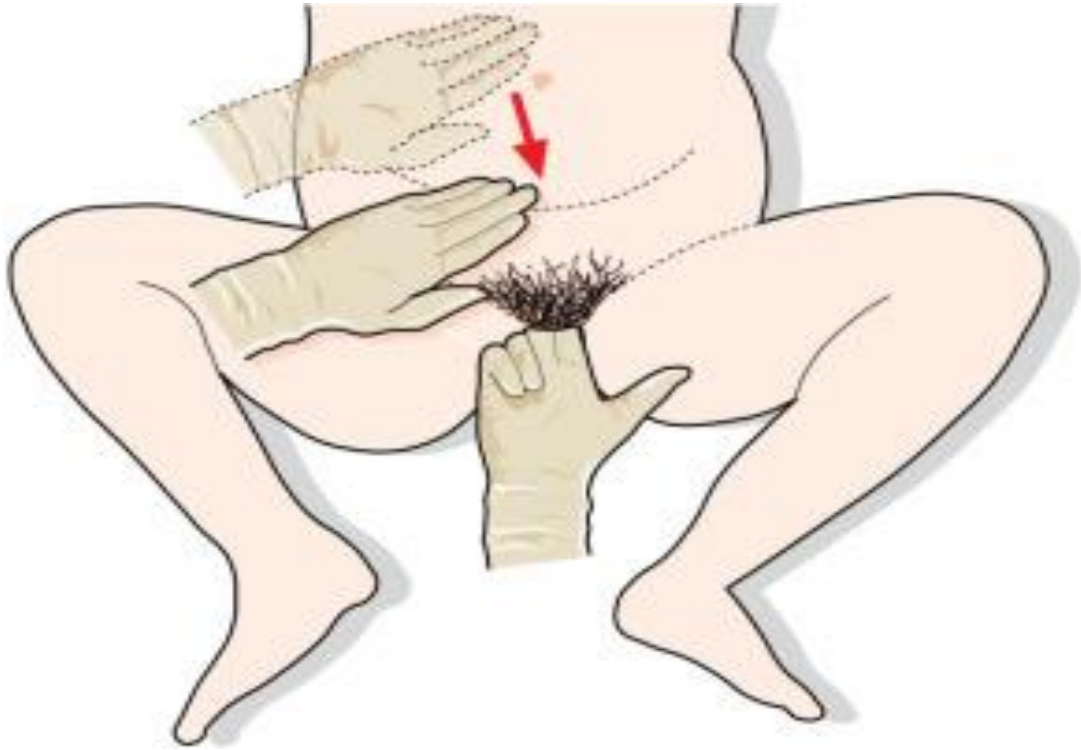
b. Shape – may be distorted by masses such as fibroids

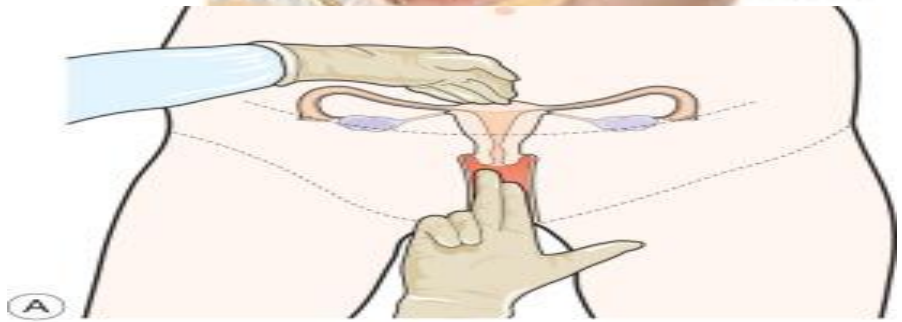
c. Position – anteverted vs retroverted

d. Surface characteristics – smooth vs nodular

e. Any tenderness during palpation? Mobility?


Pubic bone
Uterus
Bladder
Ovary
Vaginal canal
Rectum

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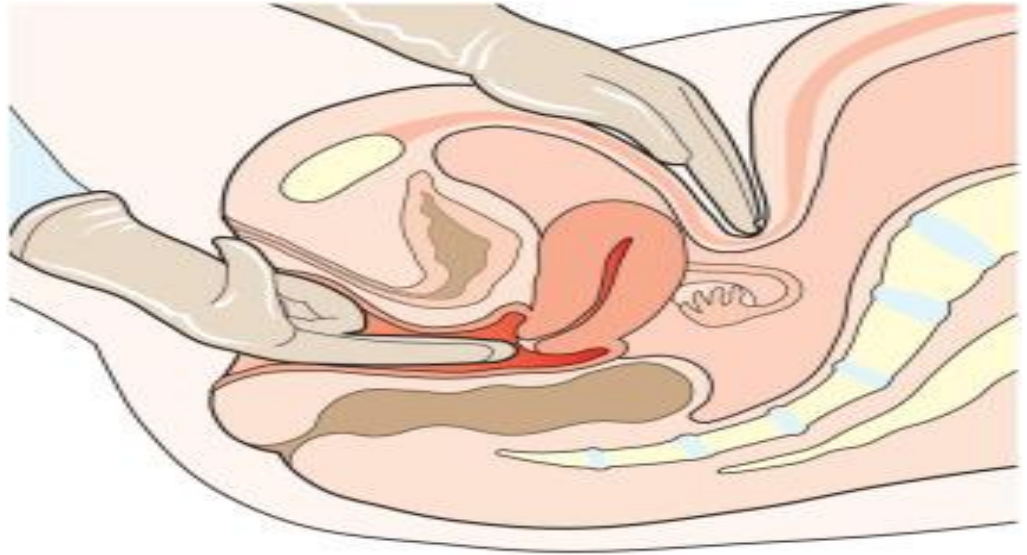
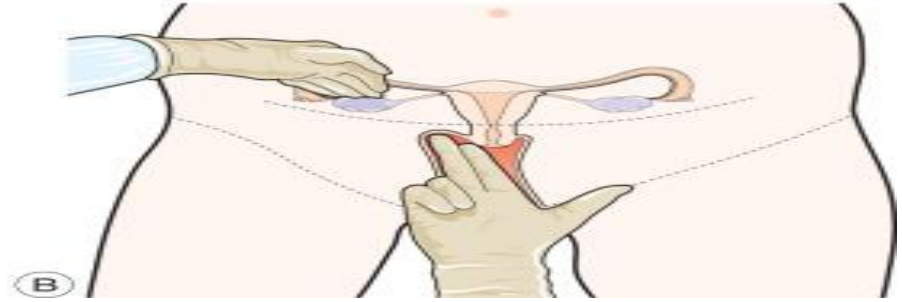



B

Ovaries and uterine tubes:

1- Assess the adnexa:

a. Place your internal fingers into the left lateral fornix

b. Place your external fingers onto the left iliac fossa

c. Perform deep palpation of the left iliac fossa whilst moving your internal fingers upwards and laterally (towards the left)

d. Feel for any palpable masses, noting their size and shape (ovarian cyst / ovarian tumour/ fibroid).

e. Repeat adnexal assessment on the other side of the patient.

To complete the examination:

1- Withdraw your fingers – inspect glove for blood or discharge

2- Re-cover the patient – allow patient time to re-dress in private

3- Thank patient

4- Dispose of equipment into clinical waste bin

5- Wash hands

6- Summarize findings

Clinical feature	General examination	Pelvic examination
Abnormal bleeding	Anaemia Underweight (hypogonadotrophic hypogonadism) Galactorrhoea, visual field defects (hyperprolactinaemia) Hirsutism, obesity, acanthosis nigricans (PCOS)	Enlarged uterus (fibroids, pregnancy) Abnormal cervix Open cervical os (miscarriage) Vaginal atrophy (most common cause of PMB)
Pain	Abdominal tenderness	Uterine excitation (acute infection or peritonism) Fixed uterus (adhesions or endometriosis) Adnexal mass (ovarian cyst)
Vaginal discharge	Rash (associated with some STIs)	Clear from cervix (chlamydia) Purulent from cervix (gonorrhoea) Frothy with strawberry cervix (trichomoniasis)
Urinary incontinence	Obesity, chronic respiratory signs (stress incontinence) Neurological signs (urge incontinence)	Demonstrable stress incontinence Uterine or vaginal wall prolapse
Abdominal distension or bloating	Ascites, weight loss, lymphadenopathy, hepatomegaly (malignancy) Pleural effusion (some malignant or benign ovarian cysts)	Pelvic mass (uterine, ovarian or indiscriminate) Fixed uterus and adnexae Abnormal vulva (skin disease or malignancy)

Bimanual examination (Demonstration)

- https://www-clinicalkey-com.uaeu.idm.oclc.org/#!/search/Bimanual%2520examination/%7B%22facetquery%22:%5B%22+contenttype:VD%22%5D%7D

Cervical screening test

Inserting the speculum

1. Warn the patient you are about to insert the speculum
2. Use your left hand (index finger and thumb) to separate the labia
3. Gently insert the speculum sideways (blades closed, angled downwards and backwards)
4. Once inserted, rotate the speculum back 90 degrees (so that the handle is facing upwards or downward)
5. Open the speculum blades until an optimal view of the cervix is achieved
6. Tighten locking nut to fix the position of the blades

Inspect the cervix

1- External os – open/closed

2- Cervical erosions – ectropion

3- Masses

4- Ulcers – e.g. genital herpes

5- Discharge – e.g. bacterial vaginosis

Types of speculums in gynecology

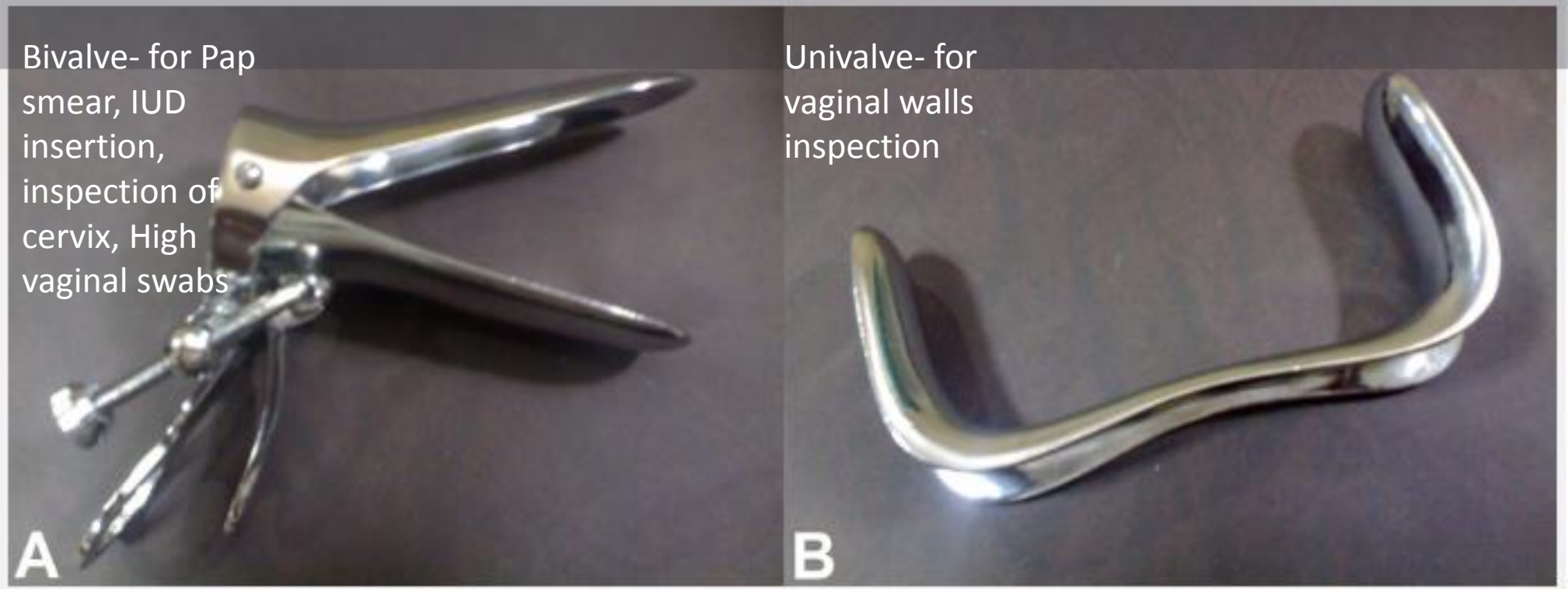
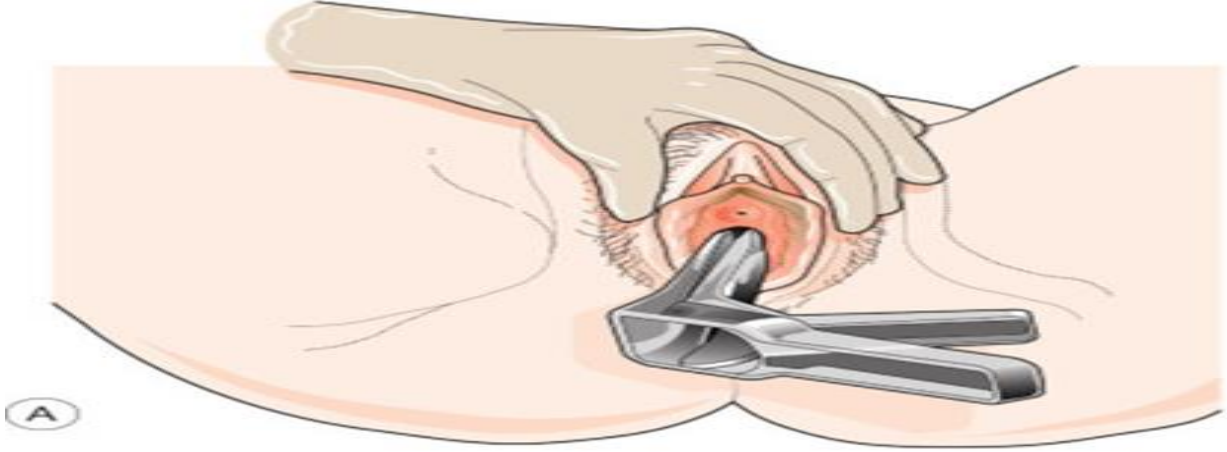
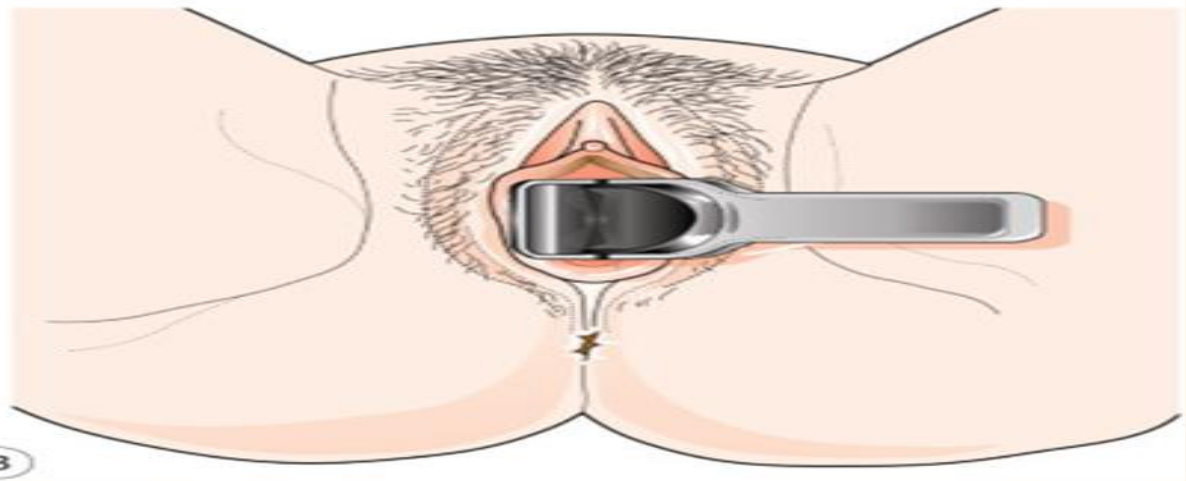
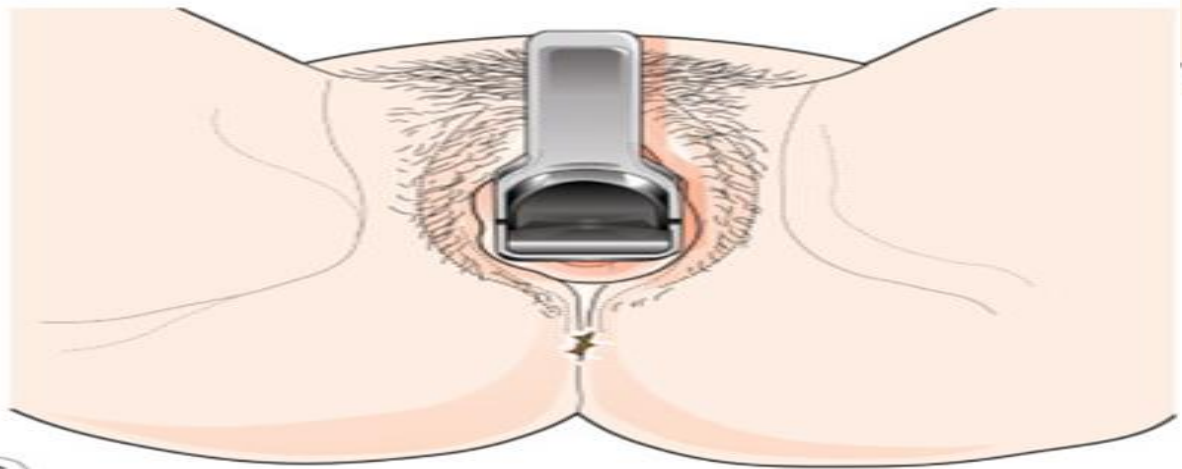


Fig 1 – Types of speculum. A – Cusco's speculum. B – Sim's speculum

Papanicolaou sampling devices. Left to right: Cervex-Brush, Cytobrush, wooden spatula, plastic spatula, tongue blade, and cotton swab.
Use of the swab and tongue blade is discouraged.


A


B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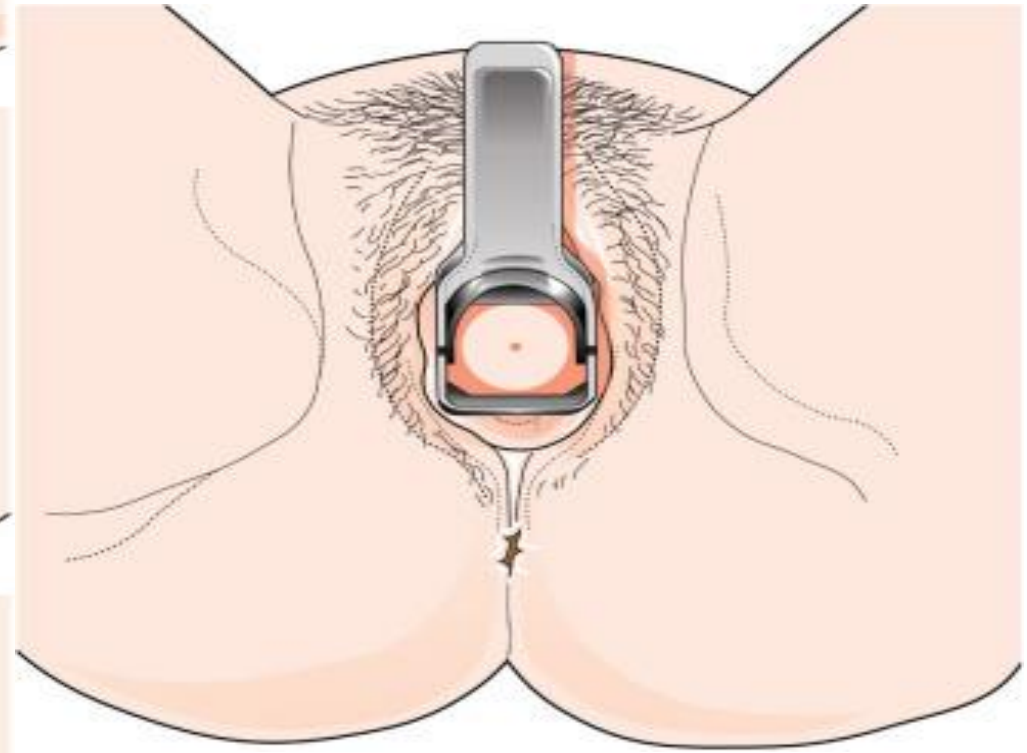
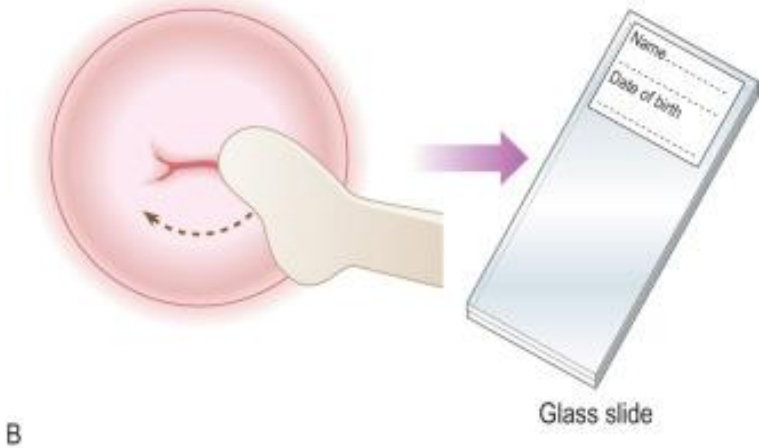


EXAMINATION SEQUENCE

- Always label the cytological medium or slide and ask the questions required to fill in the request form before starting the examination, to avoid mixing specimens.
- Clearly visualise the entire cervix.
- Liquid-based cytology
  - Insert the centre of the plastic broom into the cervical os.
  - Rotate the broom 5 times through 360 degrees Push the broom 10 times against the bottom of the specimen container.
  - Twist 5 times through 360 degrees to dislodge the sample.
  - Firmly close the lid.
- Conventional smear
  - Insert the longer blade of the spatula into the cervical os.
  - Rotate the spatula through 360 degrees (Fig. 11.28B).
  - Spread once across the glass slide.
  - Place the slide immediately into fixative (methylated spirits) for 3–4 minutes.
  - Remove it and leave it to dry in air

A



B

Obtaining the sample

1. To ensure an adequate sample is collected, the surface anatomy of the cervix must be fully visualized, including the squamous epithelium of the ectocervix, squamocolumnar junction, and the external os. The transformation zone of the cervix is the region where squamous epithelium replaces glandular epithelium in a process called squamous metaplasia.

2. Discharge covering the cervix may be removed carefully using a large swab, ensuring that the cervix is minimally traumatized.

3. Insert endocervical brush or cervical spatula through speculum into the endocervical canal

4. Rotate the brush 5 times, 360 degrees, in a clockwise direction

5. Remove endocervical brush, avoiding touching the speculum as you do so

6. For ThinPrep, the spatula and brush are to be swirled vigorously in the vial 10 times to release the specimen and then discarded.

7. Similarly, if the broom is used, it is to be pushed into the bottom of the vial 10 times and then swirled vigorously and discarded.

8. When conventional cytology is to be performed, the specimens are smeared on a glass slide and subsequently sprayed with fixative or placed in 90% alcohol solution.

9. Deposit the tip of the endocervical brush into the liquid based cytology container

10. Loosen the locking nut on the speculum and partially close the blades

11. Rotate the speculum 90 degrees, back to its original insertion orientation

12. Gently remove the speculum, inspecting the walls of the vagina as you do so

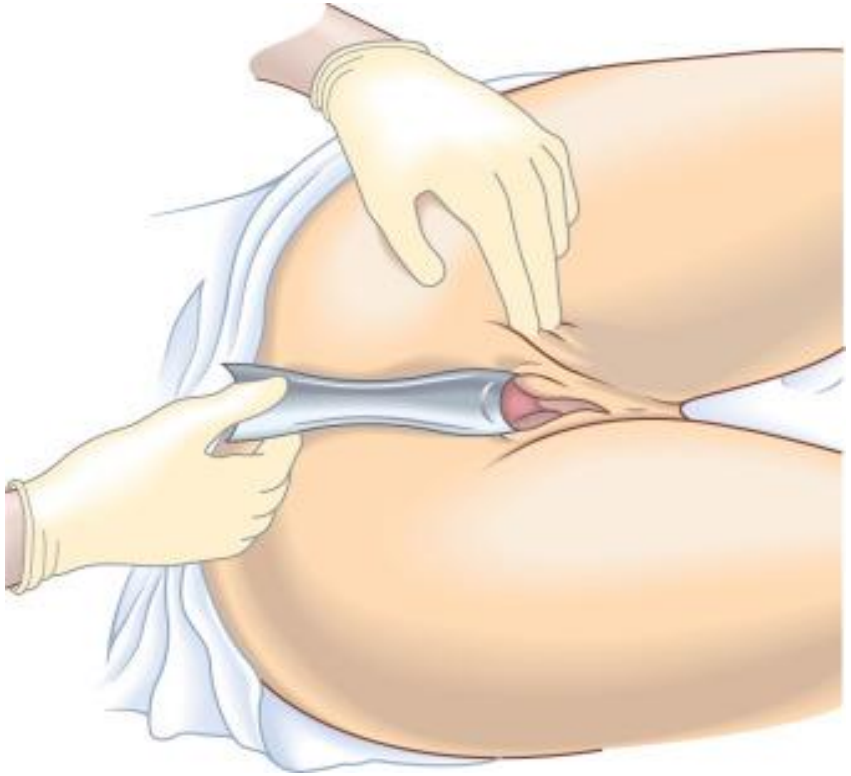
13. Re-cover the patient

14. Dispose of the speculum and gloves

15. Wash hands

To assess prolapse

- Ask the woman to lie on her left side and bring her knees up to her chest.
- Use a univalve Sims speculum, placing a small amount of lubricating jelly on the blade.
- Insert the blade to hold back the posterior wall.
- Ask the women to cough while you look for uterine descent and the bulge of a cystocoele.
- Repeat, using the speculum to hold back the anterior vaginal wall to see a rectocoele or enterocoele.



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3- Thank patient

4- Dispose of equipment into clinical waste bin

5- Wash hands

6- Summarize findings

Pap smear & High Vaginal Swab technique (videos)

- Pap Smear- Cytology Cervical Smear
- https://www-clinicalkey-com.uaeu.idm.oclc.org/#!/search/pap%2520smear/%7B%22facetquery%22:%5B%22+contenttype:VD%22%5D%7D
- HVS-
- https://www.youtube.com/watch?v=AZklKHwzyUE

THANK YOU

QUESTIONS???