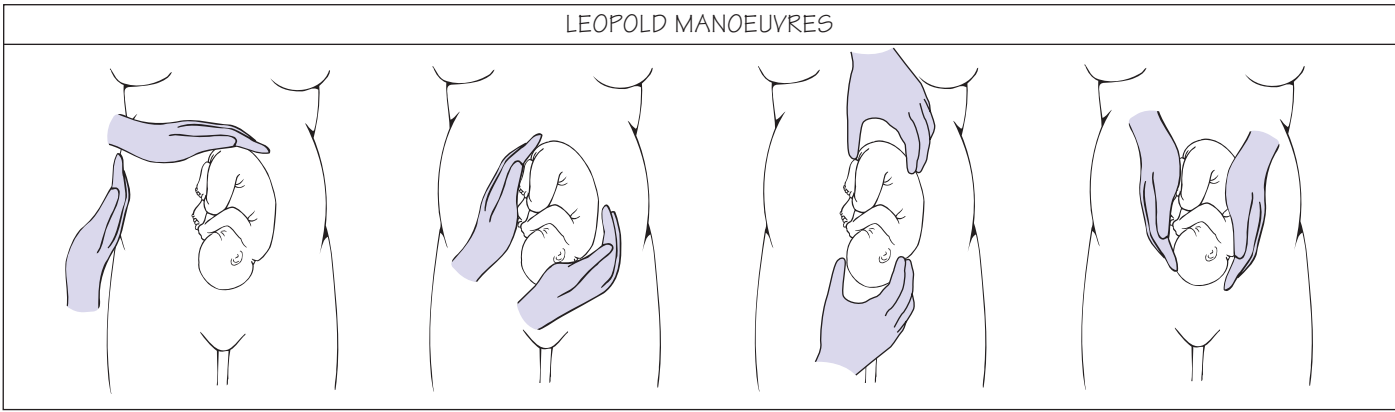


1 History taking and physical examination



SPECULA FOR GYNAECOLOGICAL EXAMINATION

<p style="text-align: center;">GRAVES</p> <ul style="list-style-type: none"> • Small: children, virginal introitus, atrophic • Medium: most women (shown above) • Large: morbid obesity, grand multiparas 	<p style="text-align: center;">PEDERSON</p> <ul style="list-style-type: none"> • Same length as Graves, but narrower • Not sexually active • Never pregnant
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PERFORMING A PAP SMEAR

The cytobrush is inserted into the external os and rotated 180°

The spatula is held firmly against the external os and rotated 360°

PELVIC EXAMINATION

<p>Bimanual examination of the uterus</p> <ul style="list-style-type: none"> • Index + middle fingers of the dominant hand are placed in the posterior fornix • The uterus is elevated by pressing up on the cervix and delivering to the abdominal hand • The position, size, shape, consistency and mobility of the uterus is noted 	<p>Bimanual examination of the adnexa</p> <ul style="list-style-type: none"> • The two fingers of the vaginal hand are moved into the deep right vaginal fornix • The abdominal hand is placed just medial to the anterior superior iliac spine • The 2 hands are brought as close together as possible and the adnexa is palpated with a sliding motion 	<p>Rectovaginal examination</p> <ul style="list-style-type: none"> • The rectovaginal septum is palpated between the vaginal index finger and the rectal middle finger • Uterosacral ligaments should be palpated as they extend posteriorly from the cervix • The best technique for retroverted uterus (shown above)

General comments

- Dress appropriately and conduct yourself in a professional manner at all times.
- Take a history before asking the patient to undress for her physical examination.
- Introduce yourself by name and title and then all members of your team.
- When taking a history always sit facing the patient and make direct eye contact. Address questions directly to the patient but be culturally sensitive. For example, some cultures discourage hand shaking. In other cultures, the husband or male family members will answer questions directed at the woman.
- Listening is important in developing a trusting relationship. Understand the problem from the patient's point of view and establish a management plan. Acknowledge important points in the history by verbal or non-verbal cues e.g. nodding.

History

- **Chief complaint.** Patients should be encouraged to express, in their own words, the main purpose of the visit. Pertinent open-ended questions can help clarify the details.
- **Present illness.** The interview should be comprehensive, but tailored to the patient's chief complaints.
- **Past medical and surgical history.** The patient should be asked to list any significant health problems. Current and prior medications should be listed and all allergic reactions should be noted.
- **Gynaecological history.** Pertinent aspects of her gynaecological history should include a detailed menstrual history (age of menarche/menopause, cycle length, and duration, last menstrual period), contraceptive history, prior vaginal or pelvic infections, sexual history, and previous surgical gynaecological procedures (including biopsies and other minor operations).
- **Obstetric history.** All pregnancies should be detailed including gestational ages, pregnancy-related complications, and pregnancy outcomes.
- **Family history.** A detailed family history should be taken. Serious illnesses (diabetes, cardiovascular disease, hypertension) or causes of death for each individual should be recorded, with particular attention to first-generation relatives. A family history of unexplained mental retardation or genetic syndromes may have implications for further pregnancies.
- **Social history.** The patient should be asked about her occupation and where and with whom she lives. She should be asked about cigarette smoking, illicit drug use, and alcohol use.
- **Review of systems.** A directed review of general symptoms is invaluable to uncover seemingly (to the patient) unrelated aspects of her health. Areas of importance include: constitutional (weight loss/gain, hot flushes), cardiovascular (chest pain, shortness of breath), gastrointestinal (irritable bowel syndrome, hepatitis), genito-urinary (incontinence, haematuria), neurological (numbness, decreased sensation), psychiatric (depression, suicidal ideations), and other body systems.

Physical examination

1 General examination

- A complete physical examination should be performed at the first visit with a chaperone present.
- The patient should be asked to disrobe completely and should be covered by an appropriate hospital gown.

2 Abdominal examination

- The abdomen should be carefully *inspected* for symmetry, scars, distension, and hair pattern; *palpated* for organomegaly or masses; and *auscultated* for bowel sounds.
- If a woman is pregnant, the 4 Leopold manoeuvres should be performed (*opposite*) to assess the number, lie, presentation, and well-being of the fetus(es).

3 Pelvic examination

- Pelvic examination should be conducted with the patient lying supine on the examining table with her legs in stirrups.
- The patient should be as relaxed as possible. This can be facilitated by explaining exactly what you plan to do before you do it and by gentle touching.
- **Inspection** of the perineum involves assessment of the hair pattern, skin, presence of lesions (vesicles, warts, pigmented nevi), evidence of trauma, haemorrhoids, and abnormalities of the perineal body. Genital prolapse can be assessed by gently separating the labia and inspecting the vagina while the patient bears down (Valsalva manoeuvre).
- **Palpation** of the labia may identify swollen or infected Bartholin's or Skene's glands.
- **Speculum examination** begins by choosing the appropriate type and size of speculum (*opposite*), making sure that it has been warmed, and then touching the tip against the patient's leg as an advance warning. Gentle spreading of the labia and downward pressure may be helpful. The speculum is then inserted by placing the blades through the introitus and guiding the tip in a downward motion toward the rectum. The blades are inserted to their full length and then opened to reveal the cervix. The vaginal canal should be examined for erythema, lesions, or discharge. The cervix should be pink, shiny, and clear.
- The **Papanicolaou (Pap) smear (opposite)** is designed to sample the transformation zone of the cervix (the junction of the squamous cells lining the vagina and the columnar cells lining the endocervical canal). The material obtained is then smeared thinly on a microscopic slide and immediately fixed by spraying. Alternatively, the spatula may be scraped to dislodge cells into a liquid-based cytology vial and prepared for cytological interpretation.
- **Bimanual examination (opposite)** allows the physician to palpate the uterus and adnexae. In the normal and non-pregnant state, the uterus is approximately 6 × 4 cm (the size of a fist). A normal ovary is approximately 3 × 2 cm in size, but is often not palpable in obese or post-menopausal women.
- A **rectovaginal examination (opposite)** may yield additional information, especially when pelvic organs are positioned in the posterior cul-de-sac. Separately, a **rectal examination** performed circumferentially with the examining finger can rule out distally located colorectal cancers. The physician may also note the tone of the anal sphincter, any other abnormalities (haemorrhoids, fissures, masses), and test a stool sample for occult blood.

Screening tests and preventative health

- Patients should routinely be counselled about the importance of screening tests, including:
 - breast self-examinations
 - mammograms
 - Pap smears
- A discussion should also be held about healthy lifestyle changes (diet, exercise), safe sexual practices, and contraception.