بسم الله الرحمن الرحيم

Gynecological history and Examination

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Gynecological history

Many women will feel anxious or apprehensive about the forthcoming consultation, so it is important that the examiner establishes initial rapport with the patient and puts them at ease. This could be done by:

- Introduce yourself by name
- Check the patient's details
- Ideally, there should be no more than one other person in the room, but any student or attending nurse should be introduced by name and their role briefly explained.

USEFUL DEFINITIONS

- Menarche – first menstrual period.
- Menopause – date of final menstrual period. This can only be defined with certainty after a year has elapsed since the final menstrual period
- Perimenopause – the years of transition where irregular cycles occur
- Menorrhagia – heavy periods.

Abnormal Bleeding

- Postcoital bleeding – bleeding occurring after intercourse.
- Intermenstrual bleeding – bleeding between periods.
- Postmenopausal bleeding – bleeding more than one year since LMP.

Irregular Bleeding

- Primary amenorrhoea – failure to menstruate by age 16.
- Secondary amenorrhoea – no menstruation for 6 months after periods are established.
- Oligoamenorrhoea – infrequent, erratic periods.

Pelvic pain

Dysmenorrhoea refers to painful menses, usually of a crampy nature it divided into:

- Primary dysmenorrhoea – periods have been painful since established menstruation has occurred.
- Secondary dysmenorrhoea – periods have become painful. This is thought to be more likely to be associated with pelvic pathology.
- Mittelshmertz – mid-cycle pain related to ovulation.

Dyspareunia – Pain or exacerbation of underlying pain during sexual intercourse it divided into:

- Deep dyspareunia implies pathology of the upper genital tract.
- Superficial dyspareunia is more likely to represent a vaginal cause.
- Vaginismus is also a common cause of dyspareunia, where the vaginal muscles tense during attempted penetration

Gynecological history follows the standard principles of medical history taking but there are a number of other issues that are relevant to gynecology.

Standard history taking	Additional features relevant to gynaecology
Age Presenting complaint Past medical history Medication history Allergies Social history Family history Systemic enquiry	Parity Obstetric history Contraception and fertility requirements Smear history Menstrual history – this will often be part of the presenting complaint

Gynecological examination

- Any examination should always be carried out with the patient's consent and with appropriate privacy and sensitivity. Ideally, a chaperone should be present throughout the examination.

The examination includes:

General and systemic examination

Gynecological examination

- Breast examination
- Abdominal examination
- Pelvic examination

GENERAL AND SYSTEMIC EXAMINATION

- Built—Too obese or too thin—May be the result of endocrinopathy and related to menstrual abnormalities
- Nutrition—Average/Poor
- Stature—including development of secondary sex characters
- Pallor
- Jaundice
- edema of legs
- Teeth, gums and tonsils—for any septic foci
- Neck—Palpation of thyroid gland and lymph nodes, especially the left supraclavicular glands
- Cardiovascular and respiratory systems—Any abnormality may modify the surgical procedure, if it deems necessary
- Pulse , Blood pressure.

Breast Examination

- This should be a routine especially in women above the age of 30 to detect any breast pathology

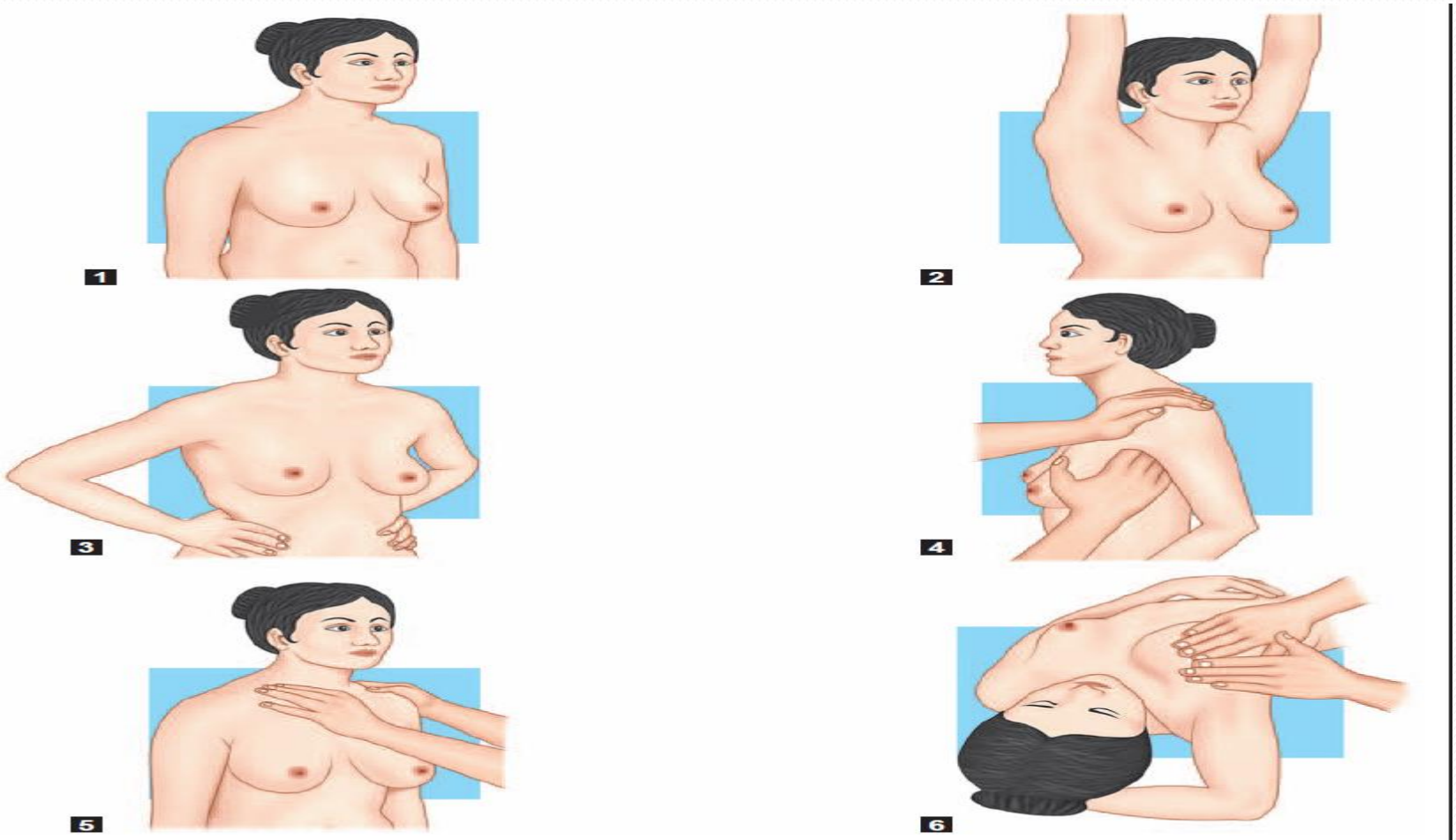


Fig. 9.1. Examination of the breasts: 1. Inspection with the arms at her sides; 2. Inspection with the arms raised above the head; 3. Inspection with hands at the waist (with contracted pectoral muscle); 4. Palpation of the axillary nodes; 5. Palpation of the supraclavicular nodes; 6. Palpation of the outer half of the breast (a pillow is placed under the patient's shoulder)

Abdominal examination

Prerequisites

- Bladder should be empty
- The patient is to lie flat on the table with the thighs slightly flexed and abducted
- The physician usually prefers to stand on the right side
- Presence of a chaperone (a female) for the support of the patient and the physician

Actual steps:

- Inspection
- Palpation
- Percussion
- Auscultation

Inspection

- Skin quality and fat or wasting.
- Distension or any visible tumour.
- Operation scars, especially a laparoscopy crescent at the umbilicus or lower abdomen curved scar for pelvic surgery.

Palpation

This is done lightly at first to test for any localized tenderness or rigidity. Deep palpation is used to confirm the presence of a tumour or enlargement, especially of uterus or ovaries

Percussion

If there is a central tumour it will be dull to percussion with hollow sounds from the flanks. Ascites may produce shifting dullness in the flanks and central resonance

Auscultation

Although this will rarely help, it may give reassurance about intestinal activity, and bowel sounds may be heard

PELVIC EXAMINATION

Pelvic examination includes:

Inspection of the external genitalia

Vaginal examination

- – Inspection of the cervix and vaginal walls
- – Palpation of the vagina and vaginal cervix by digital examination
- – Bimanual examination of the pelvic organs

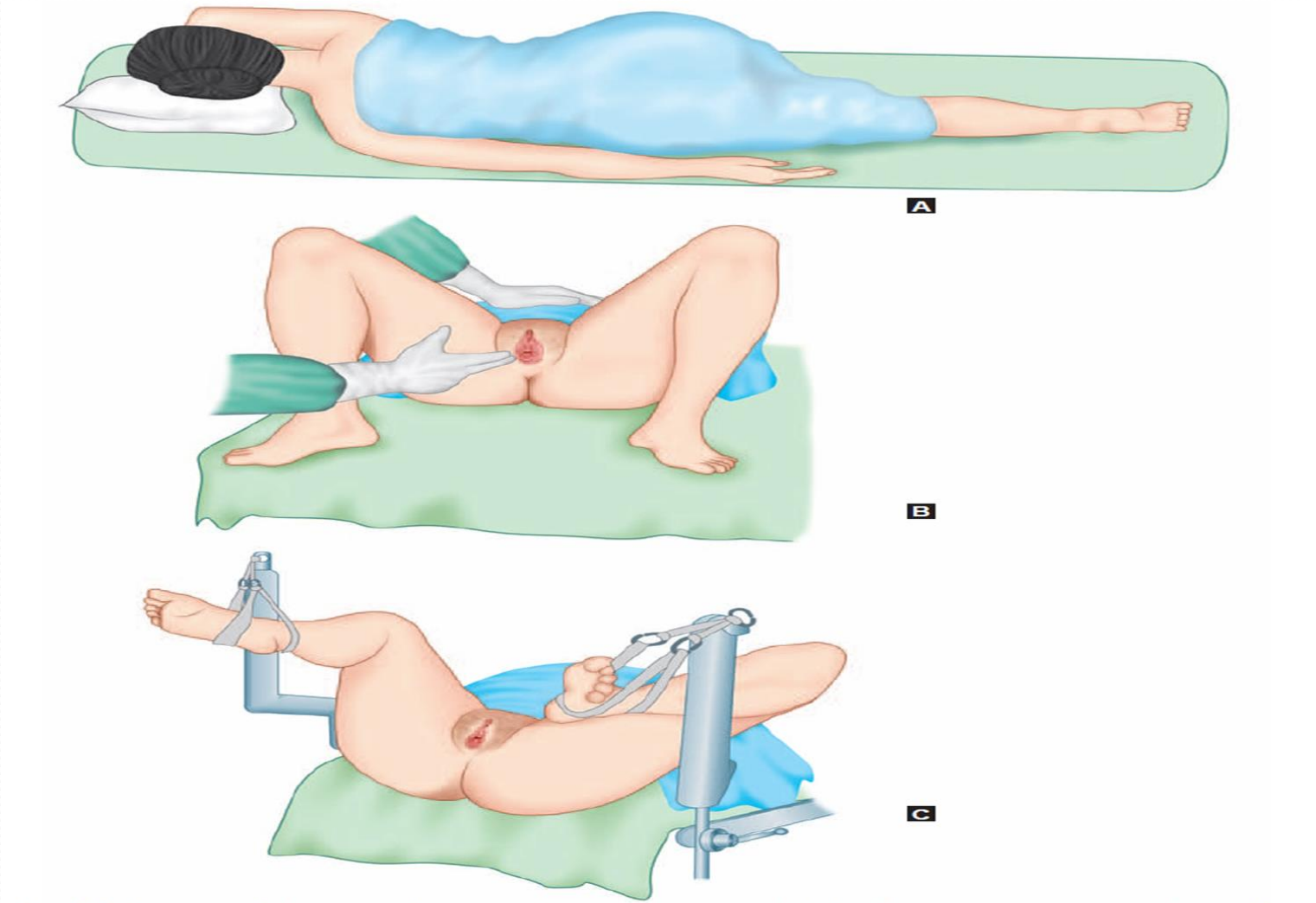
Rectal examination

Rectovaginal examination.

Prerequisites

- The patient's bladder must be empty—the exception being a case of stress incontinence
- A female attendant (nurse or relative of the patient) should be present by the side
- To examine a minor or unmarried, a consent from the parent or guardian is required
- Lower bowel (rectum and pelvic colon) should preferably be empty
- A light source should be available
- Sterile gloves, sterile lubricant (preferably colorless without any antiseptics), speculum, sponge holding forceps and swabs are required.

Position of the patient



Figs 9.3: Positions of the patient for gynecological examination: (A). Sims' position — The patient lies on her left side with right knee and thigh drawn up towards the chest, the left arm along the back; (B). Dorsal position; (C). Lithotomy position

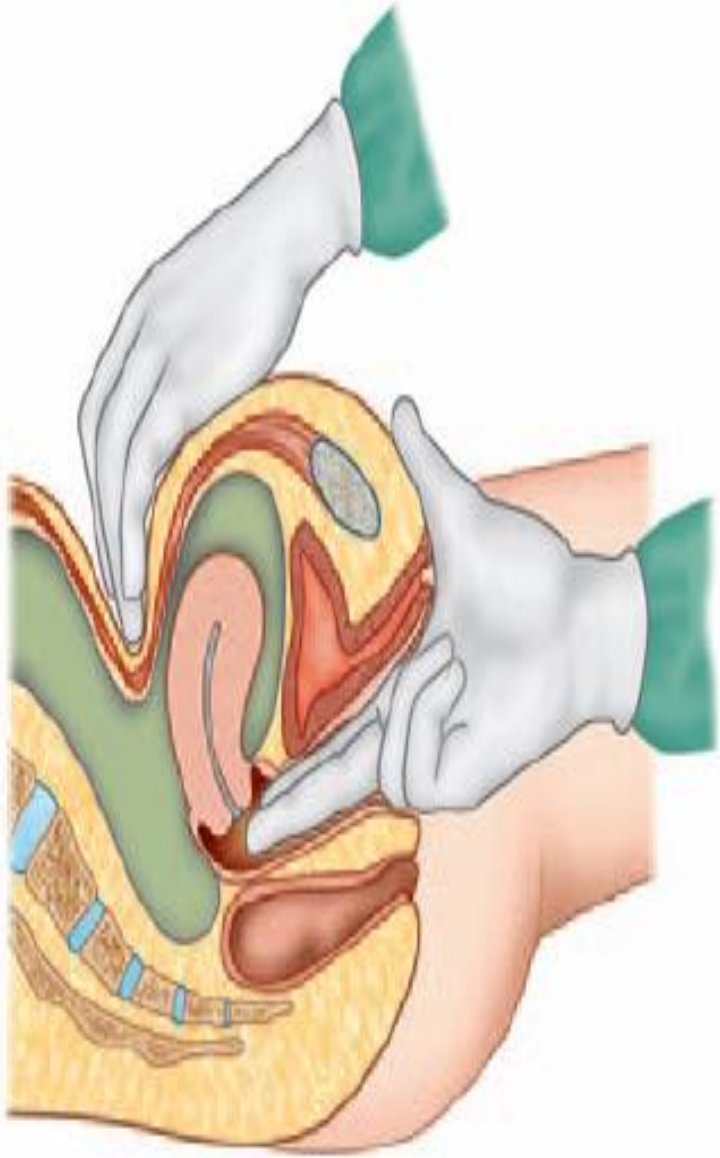
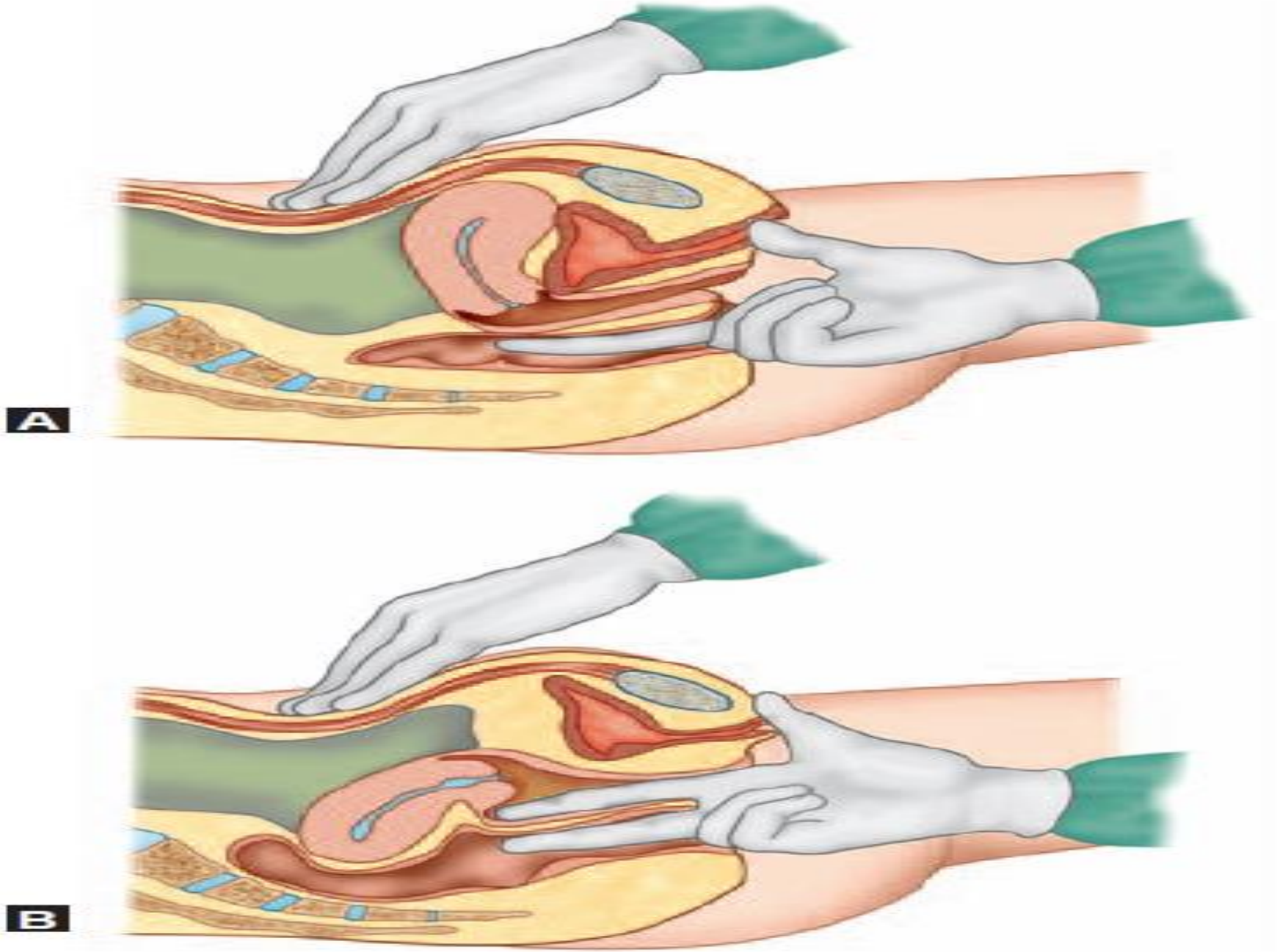


Fig. 9.8. Bimanual examination of the uterus

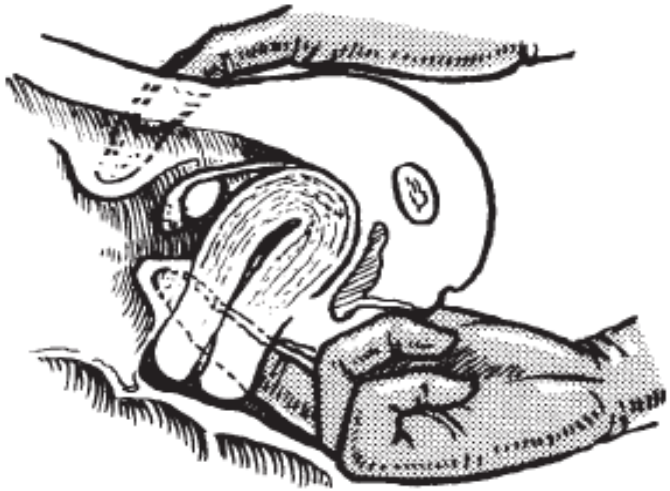
Fig. 9.7. Position of the fingers during bimanual examination



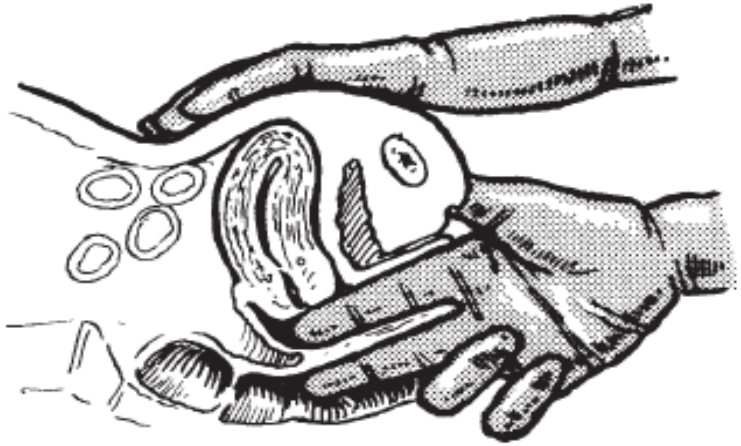
Figs 9.9A and B: (A) Rectoabdominal; (B) Rectovaginal examination

1. The vagina and cervix are palpated and any hardness or irregularity noted.

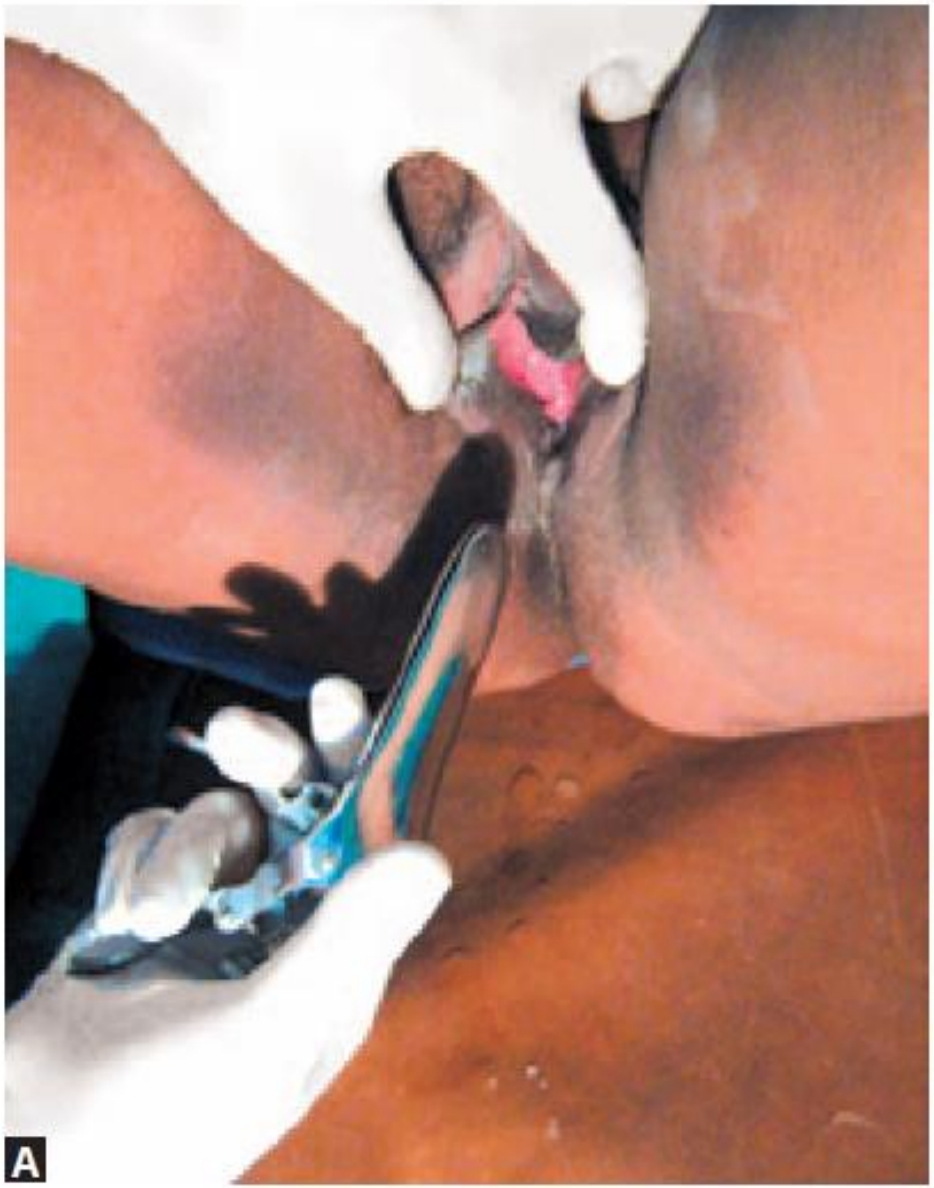
2. The whole uterus is identified, and size, shape, position, mobility and tenderness are noted.

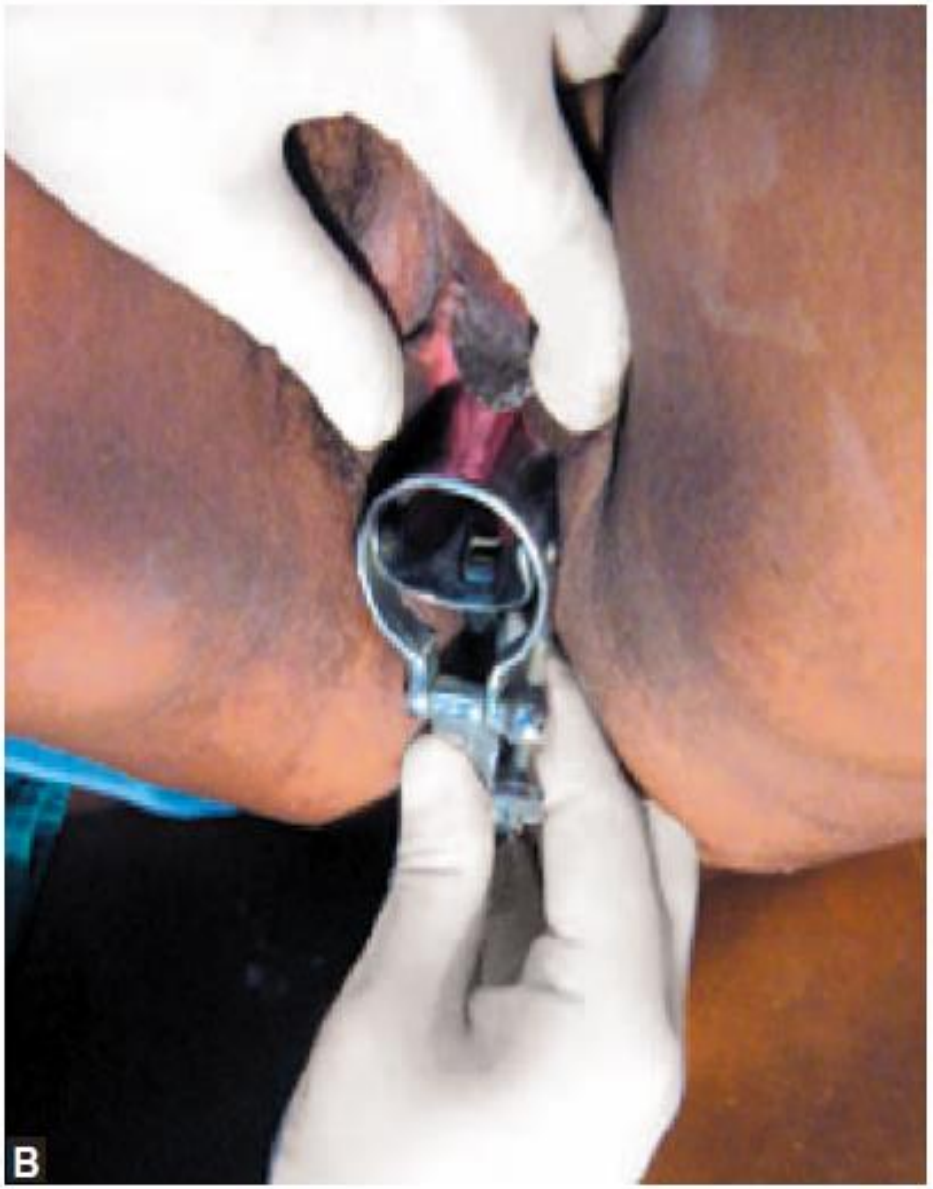


3. The lateral pelvis is palpated and any swelling noted. Normal adnexa are difficult to feel, unless the ovary contains a corpus luteum.

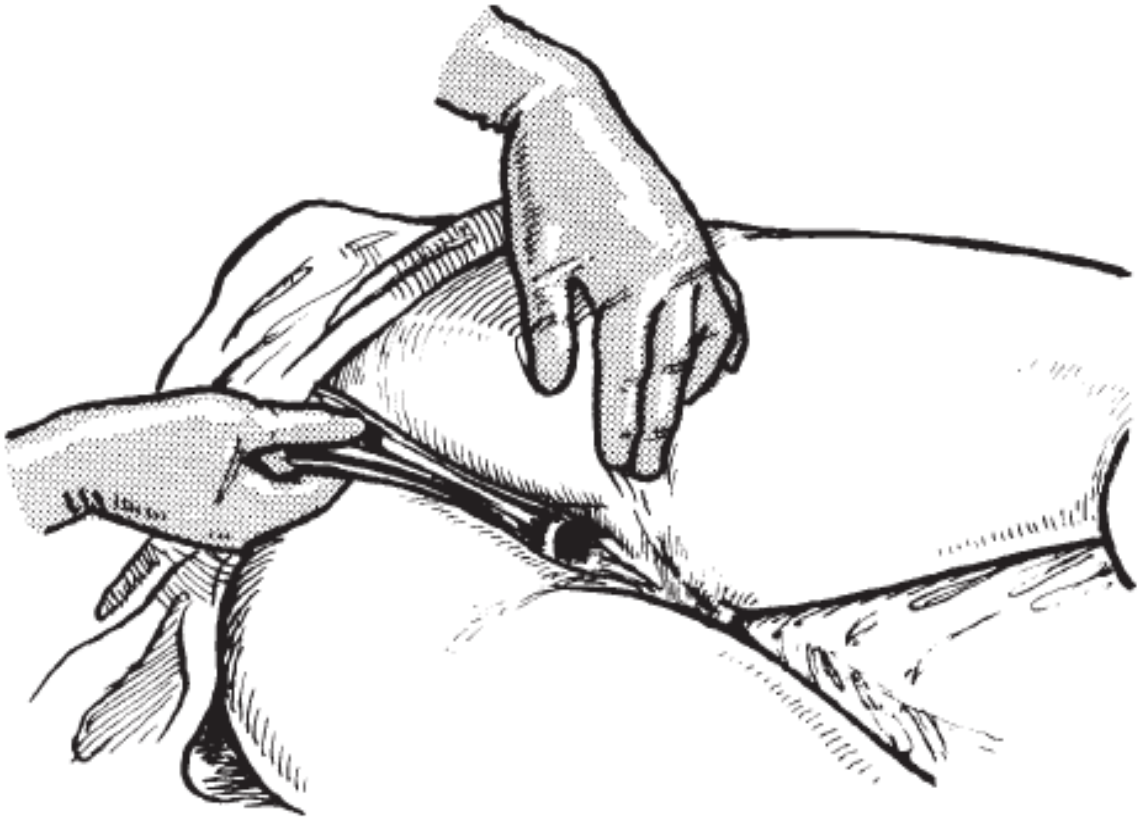


4. Sometimes rectovaginal examination is helpful, particularly if the rectovaginal septum is to be examined, for example, in assessment of extent of malignant disease.





Figs 9.5A and B: Introduction of Cusco's speculum: (A) The transverse diameter of the closed blades are placed in the anteroposterior position and inserted slightly obliquely to minimize pressure on the urethra; (B) Blades are inserted in a downward motion and then rotated. Rotate to 90° and then to open up the blades. Inspection is then made using a good light



SIMS' SPECULUM (the duckbill speculum) is designed to hold back the posterior vaginal wall so that air enters the vagina because of negative intra-abdominal pressure, and the anterior wall and cervix are exposed.

In this picture, the patient is in Sims' position (semi-prone) which is useful if the anterior wall is to be studied (e.g. if fistula is suspected).

Investigations

Once the examination is complete, the patient should be given the opportunity to dress in privacy and come back into the consultation room to sit down and discuss the findings. You should now be able

- to give a summary of the whole case
- formulate a differential diagnosis.
- This will then determine the appropriate further investigations (if any) that should be needed. Swabs and smears should be taken at the time of the examination and a midstream specimen of urine (MSU) when the patient empties her bladder before the examination. The need for further investigations, such as ultrasound, colposcopy and

Urodynamics this depend on the case, also laproscopy .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спасибо
dank je
gracias
thank you
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obrigado
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arigato
dakujem
grazie
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