The gynaecological history and examination

* patient's name
* Age
* Occupation
* Residence
* Religion
* Marital status
* Blood group

Chief complaint : a brief statement of the general nature and duration of the main complaint .

History of presenting complaint : this section should focus on the presenting complaint , but certain important points should always be enquired about :

* Abnormal menstrual loss.
* Pattern of bleeding- regular or irregular.
* Intermenstrual bleeding.
* Amount of blood loss- great or less than usual.
* Number of sanitary towels or tampons used.
* Passage of clots or flooding.
* Pelvic pain-site of pain , nature, and relation to periods .
* Anything that aggravates or relieves the pain, radiation of pain , associated symptoms.
* Vaginal discharge- amount ,colour,odour,presence of blood.

Obviously if the presenting complaint is one of subfertility or is urogynecological , the history must be appropriately tailored.

Review of other systems:

* Appetite , weight loss or gain.
* Bowels , micturition.
* Cardiovascular , respiratory and other systems.

Usual menstrual cycle:

* Age of menarche.
* Usual duration of each period and length of cycle.
* Painful cycles.
* First day of the last period.
* Age of menopause.

Previous gynaecological history:

* Previous gynaecological surgery or treatment.
* The date of last cervical smear.
* History of discomfort , pain , or bleeding during intercourse.
* The use of contraception and type of contraception used.
* History of infertility.

Previous obstetric history:

* Number of children with ages and birth weights.

* Any abnormalities with pregnancy , labour or the puerperium.

* Number of miscarriages and gestation at which they occurred.

* Any termination of pregnancy with record of gestation age and any complications.

Previous medical history:

* Any serious illness or medical disease.

Previous surgical history :

* Previous operations.
* blood transfusion.

Family history:

* Any medical diseases.

* History of gynaecological or obstetric conditions.

Drug history:

* Allergy to drugs.

* Current drug use.

Social history:

* Smoking and alcohol use.
* marital status.
* Family problems.

CONTENTS

Introduction

General examination

Chest examination- heart, lungs and breast examination

Abdominal examination

Pelvic examination - Digital and speculum examination

INTRODUCTION

Gynaecological examination confirms presence of pathology suspected from the gynaecological history.

Always explain to the patient the need and the nature of the proposed examination.

Obtain an informed verbal consent.

The examiner (male or female) should be accompanied by another female (chaperone).

Examination performed in a private setting, respecting patient's privacy at all times.

Patient should be covered at all times and only relevant parts of her anatomy exposed.

GENERAL EXAMINATION

Observe general appearance, state of nutrition, gait, level of consciousness, responsiveness etc.

Height and weight - BMI

Hands and arms- assess tobacco-stained fingers, clubbing, pulse, blood pressure, temperature.

Head and neck- facial hair distribution (also other secondary sexual development and hair distribution), anaemia, jaundice, cyanosis, acne, lymphadenopathy, thyroid disease (enlarged thyroid gland, tremor etc)

Legs - ankle swelling

CHEST EXAMINATION

Assess the heart and lungs for signs of disease

BREAST EXAMINATION

Position patient reclining at 45 degrees with arms at the sides

Inspection – positions at rest, arms above head, on hips

1) Development and symmetry of breasts and nipples.

2) Reddening of skin, ulceration or dimpling (peau d'orange)

3) Retraction of nipple (CA breast)

4) Nipple discharge- blood, serous or milky

Palpation- palpate systematically for lumps with the flat part of the fingers, through all 4 quadrants. If present, describe the characteristics of the lump- location, size, shape, surface, edge, consistency and mobility in relation to deep and superficial structures.

Palpate the axillae for lymph nodes – describe if present.

Abdominal examination :

Inspection :

The contour of the abdomen for any distension or mass

Surgical scars, dilated veins or striae gravidarum

Laparoscopy scars , pfannenstiel scars

The patient is asked to cough or raise her head for any herniae , divarication of the rectus muscles

Hair distribution , umbilicus

Palpation :

- First, if the patient has any pain ,she should be asked to point to the site . this area should not be examined until the end of palpation.

- Using the right hand , examine the left lower quadrant and proceed to the right lower quadrant

- palpate for masses ,liver , spleen and kidneys

- if a mass is present but it is possible to palpate below, it is more likely to be abdominal mass , in case of pelvic mass one cannot palpate below it

- signs of peritonism : guarding and rebound tenderness

- examination for inguinal herniae and lymph nodes

Percussion :

Shifting dullness , ascitic fluid will settle down into a horseshoe shape and dullness in the flanks can be demonstrated, as the patient moves over to her side the dullness will move to her lowermost side. A fluid thrill can also be elicited.

An enlarged bladder due to urinary retention will also be dull to percussion

Auscultation :

Postoperative patient listen for bowel sounds.

PELVIC EXAMINATION

Inspection and palpation of the vulva

Speculum examination

Bimanual digital examination

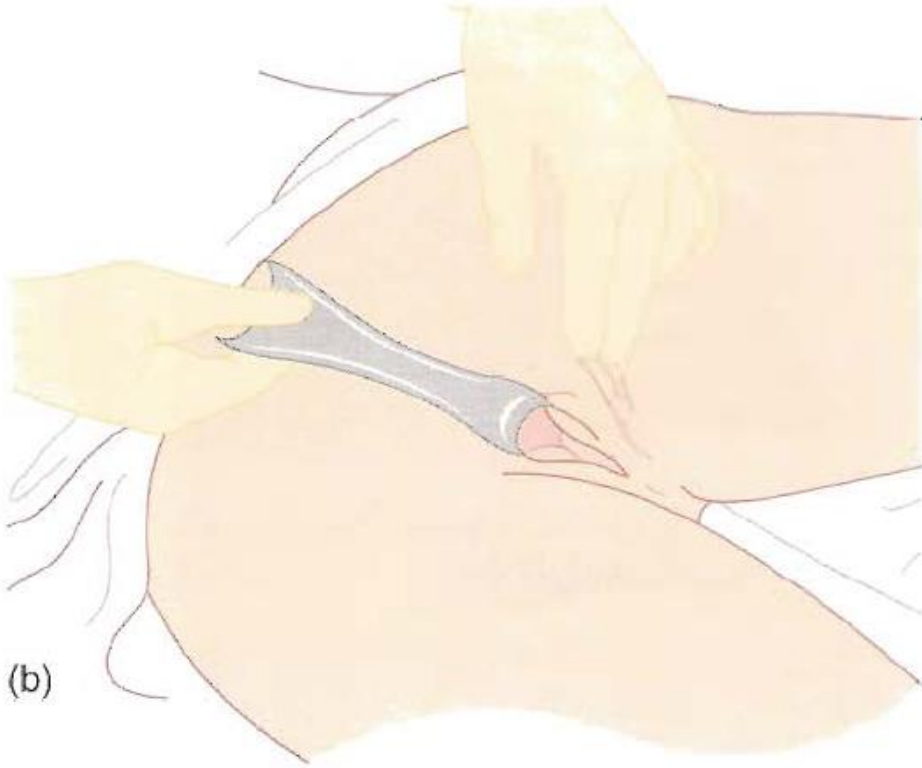
Pelvic examination :

Patient's verbal consent and a female chaperone should be present for any intimate examination

The external genitalia are first inspected under good light with the patient in dorsal position , the hips flexed and abducted and the knees flexed

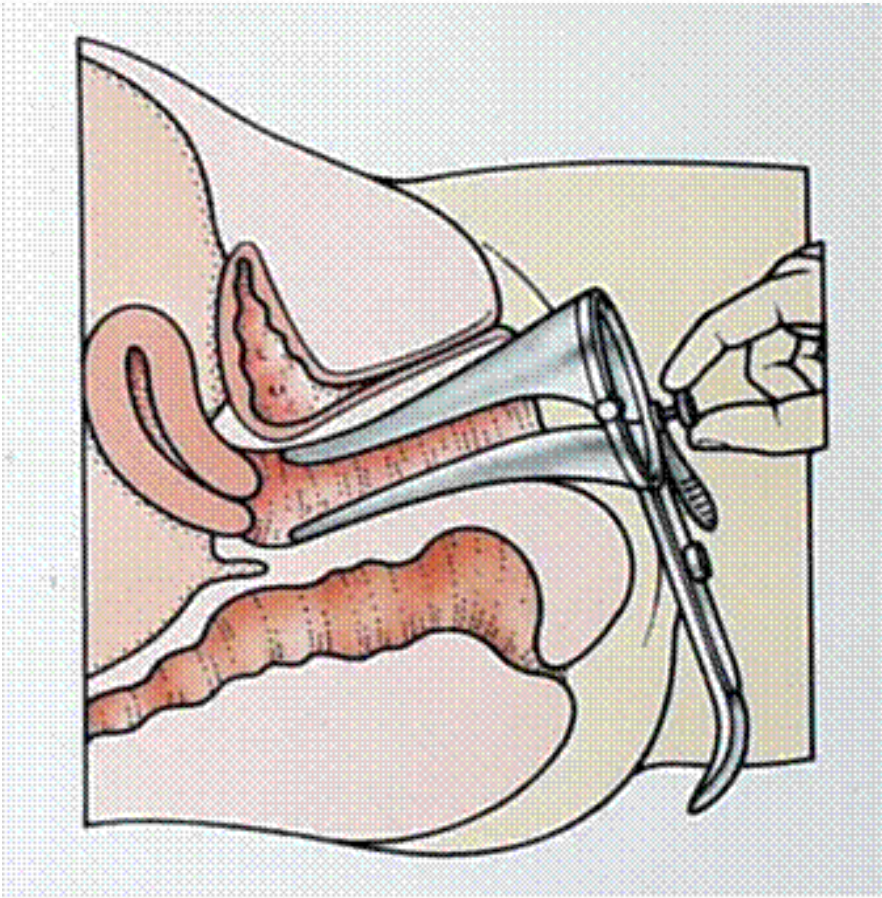
The left lateral position is used for examination of prolapse or to inspect the vaginal wall with a Sim's speculum

The patient is asked to strain down to detect any prolapse and also to cough ,as this will show the sign of stress incontinence



igure 1.2 (a) Sims' speculum. (b) Sims' speculum exposing anterior vaginal wall.

Cusco's bivalve speculum is inserted to visualize the cervix (after warming it) a smear test could be performed at the same time



SPECULUM EXAMINATION

Inform patient that the speculum will be passed to visualize the vaginal canal and the cervix.

A sterile duck-billed/bivalve Cusco speculum checked to ensure in working order.

Speculum assembled with blades in closed position and lock mechanism fully loosened.

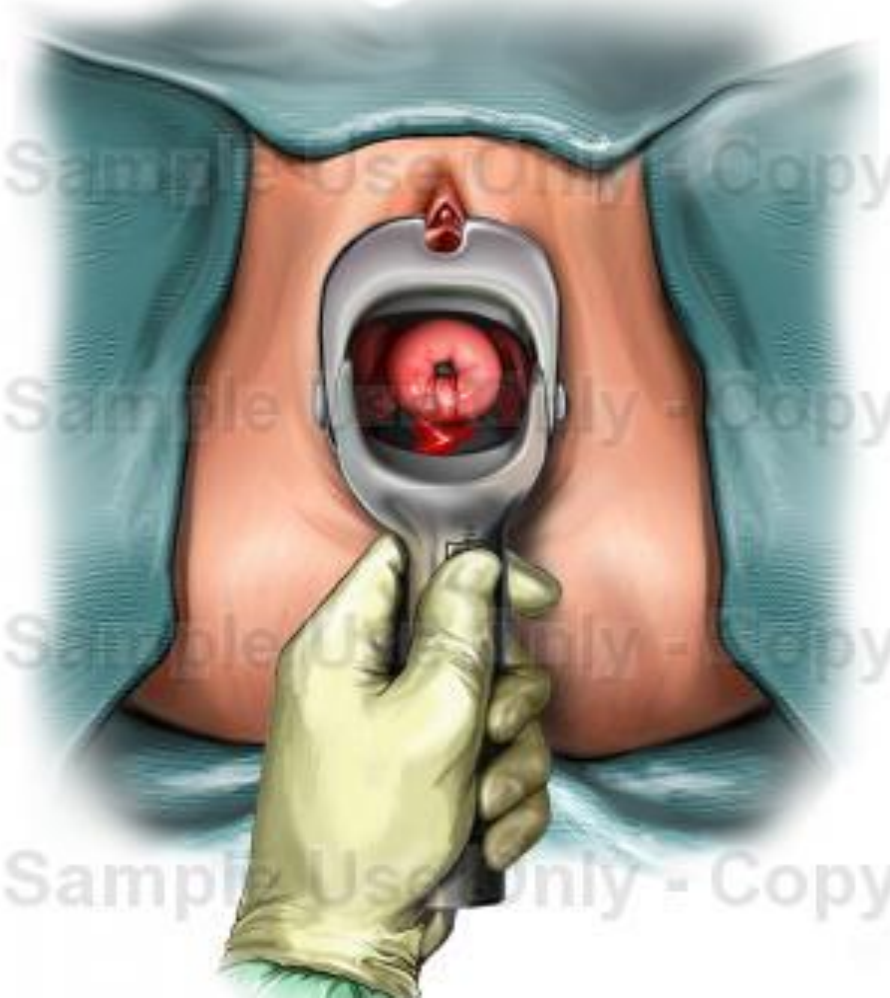
Speculum should be lubricated with KY jelly or lukewarm water before insertion (Note Pap)

SPECULUM EXAMINATION

1) Visualisation of the cervix

- The full length of speculum is inserted up the length of the vaginal canal. Pushing the handles together opens the blades of the speculum which is manoeuvered so that the cervix is fully visualized.
- The screw adjuster on the handle is then locked so that the speculum is maintained in place.
- The cervix is then inspected.

SPECULUM EXAMINATION – Note that speculum in illustration is not a Cusco….



Inspect the cervix:

- Type of cervical os- small round dimple (nulliparous os) or os in the shape of a smile (multiparous os)
- Colour- normally pink, may be a redder area around the os, known as cervical ectropion, or tinged blue if pregnant, red in cervicitis
- Secretions/ discharge - observe colour (eg cervical mucus if ovulating, blood if menstruating)
- Presence of growths/ tumours- usually cauliflower-like and friable, i.e. bleeds on touch (indicates malignancy)
- Ulcerations, scars and retention cysts (Nabothian follicles)
- The cervical smear/“Pap" smear is taken at this stage

SPECULUM EXAMINATION

Papanicolau/“Pap" smear:

Indications:

Cervical cancer screening-

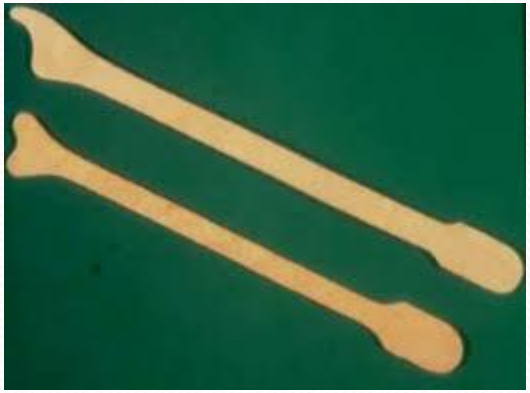
Within 5years of becoming sexually active

Annually in high-risk groups such as patients with recurrent STI's and HIV

Post-coital bleeding

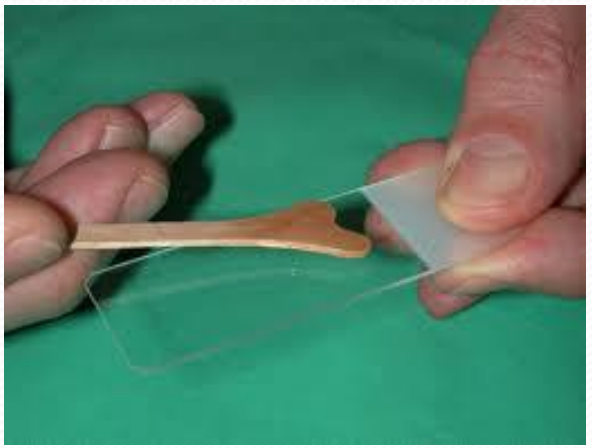
Postmenopausal bleeding

1st trimester of pregnancy

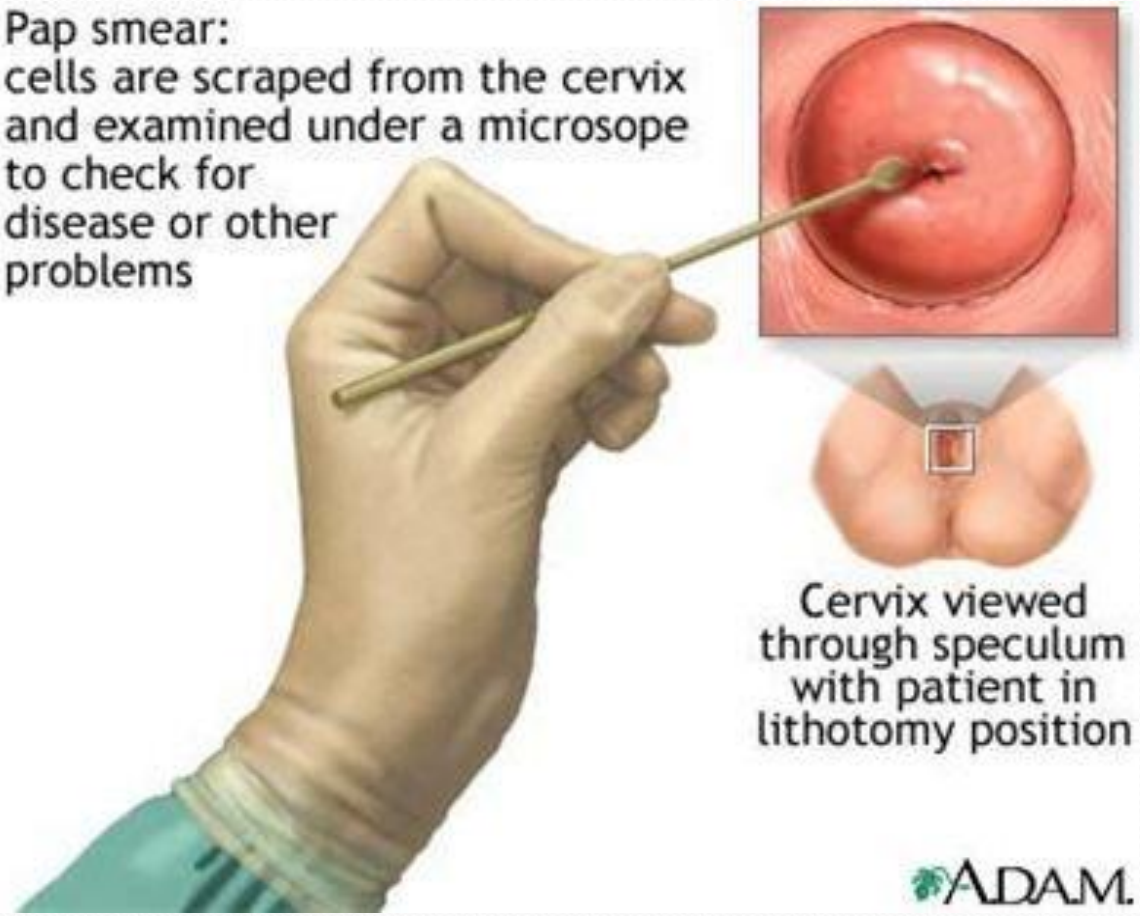


Additional equipment required

- Ayres spatula or an endocervical brush eg Craigbrush
- Swabs
- Fixative spray
- Two glass slides labeled with patient's name



PAP SMEAR – this is not an Ayre's spatula…



SPECULUM EXAMINATION

2) Inspecting the vagina

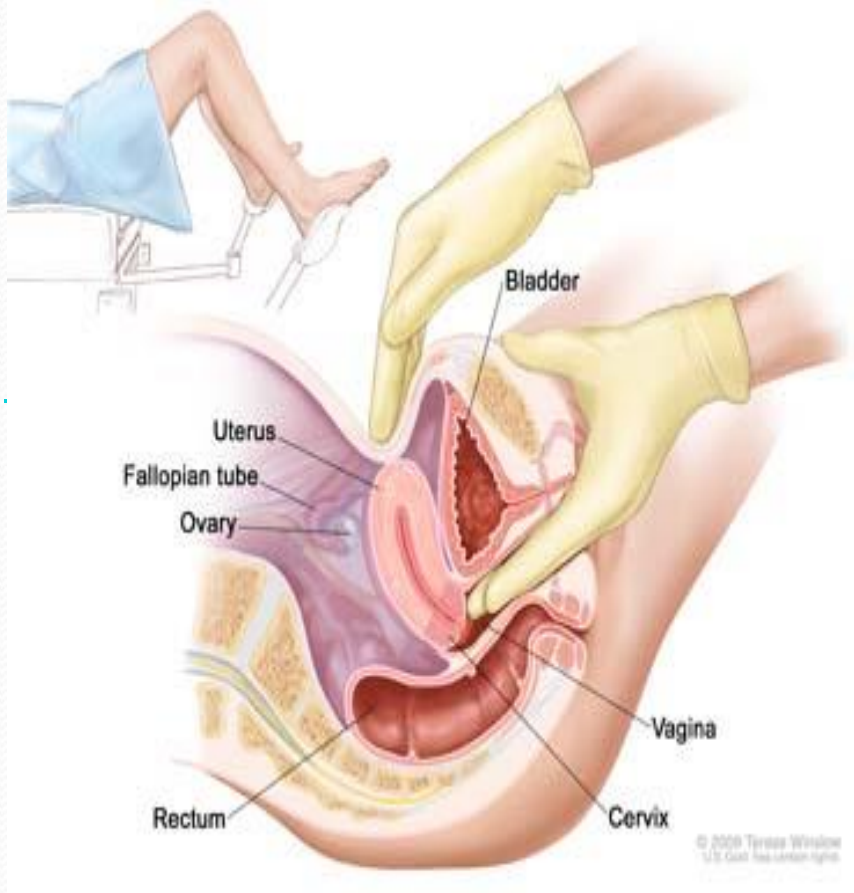
- With the speculum in this position, inspect the vaginal side-walls for any ulcers, discolouration, discharge or growths.
- The handles of the speculum are then unlocked and the blades allowed to close but not completely, leaving a 1cm gap between the tips.
- Withdraw the speculum gently whilst inspecting the anterior and posterior walls of the vagina, again looking for any ulcers, discolouration, discharge or growths.
- The speculum is placed in a bowl with disinfectant, for later cleaning and re-sterilization (autoclave).

BIMANUAL DIGITAL EXAMINATION

1) Assessing the cervix:

Vaginal fingers locate the cervix and the external cervical os:

- Determine whether it is **open or closed**
- Determine the **length of** the cervix
- Directed posteriorly when the uterus is anteverted
- **Consistency** usually firm when normal, but hard due to fibrosis or carcinoma, and soft in pregnancy
- Gently and minimally move the cervix from side-to-side while watching patient's face to ascertain whether this is painful = **cervical excitation tenderness** - positive in the presence of pelvic inflammation



BIMANUAL DIGITAL EXAMINATION

2) Assessing the uterus:

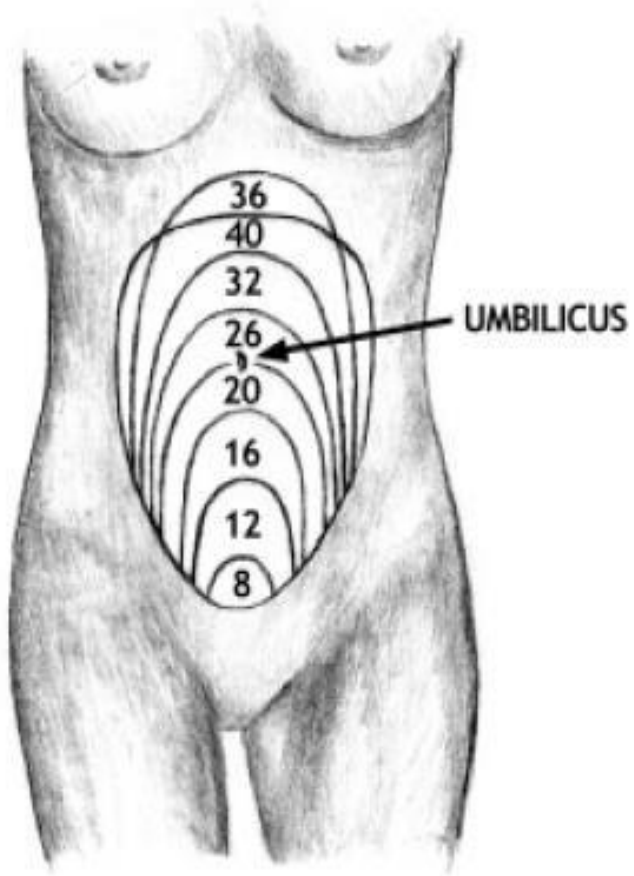
The vaginal fingers then push on or behind the cervix to elevate the uterus upwards towards the anterior abdominal wall, while the left hand is placed supra-pubically to palpate the uterus between the two hands(bimanual).

- Assess **size** of uterus (in gestational weeks)
- **Shape** (globular is almost round and smooth, while bossellated means lumpy as in a tumour)
- **Consistency** (normally firm, soft in early pregnancy, hard if a tumour present)
- **Position** of uterus (if anteverted it is angled/ tipped towards the ant. abdominal wall, while if retroverted, it is angled backwards away from the ant. abdominal wall)

Presence of any **tenderness** -

Mobility (mobile or fixed) -

Figure 1. Uterine Size Based On Weeks Of Gestation.

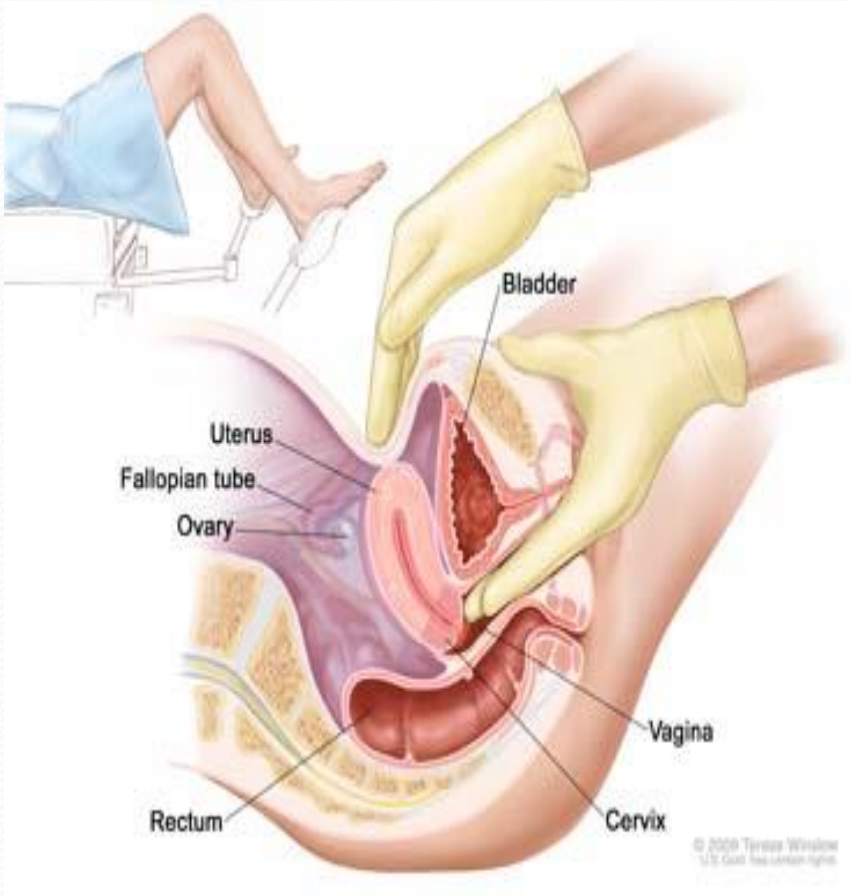


BIMANUAL DIGITAL EXAMINATION

3) Assessing the adnexae:

The vaginal fingers are now moved into one of the **lateral fornices** with the abdominal hand moving to the corresponding iliac fossa.

Assess for any **adnexal masses** (ovaries and fallopian tubes) on both sides - size, shape, **tenderness**, etc.



BIMANUAL DIGITAL EXAMINATION

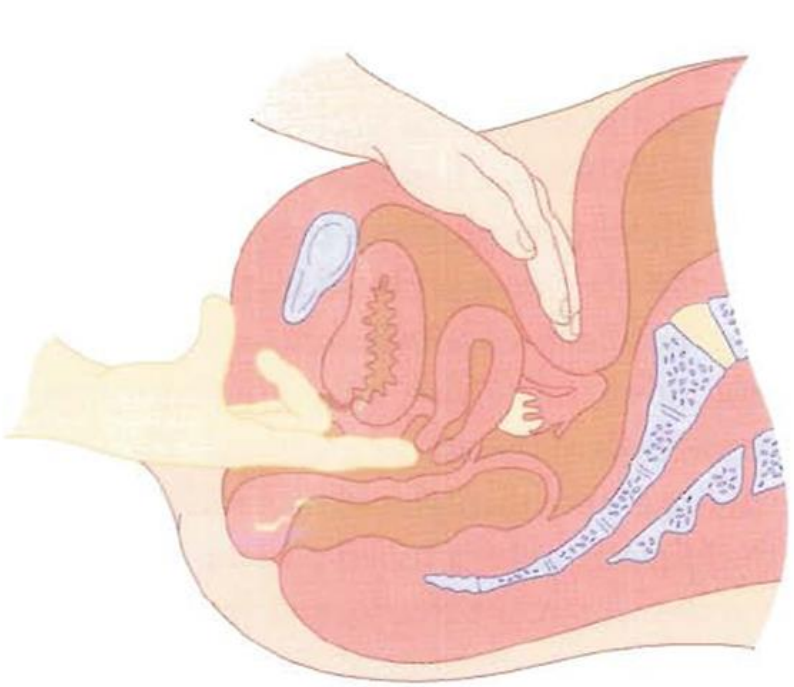
4) Assessing the Pouch of Douglas (recto-uterine pouch):

-The vaginal fingers now placed into the **posterior fornix** of the vagina and its shape is assessed (normally concave away from the fingers, but may be convex towards the fingers if there is a mass in the Pouch of Douglas).

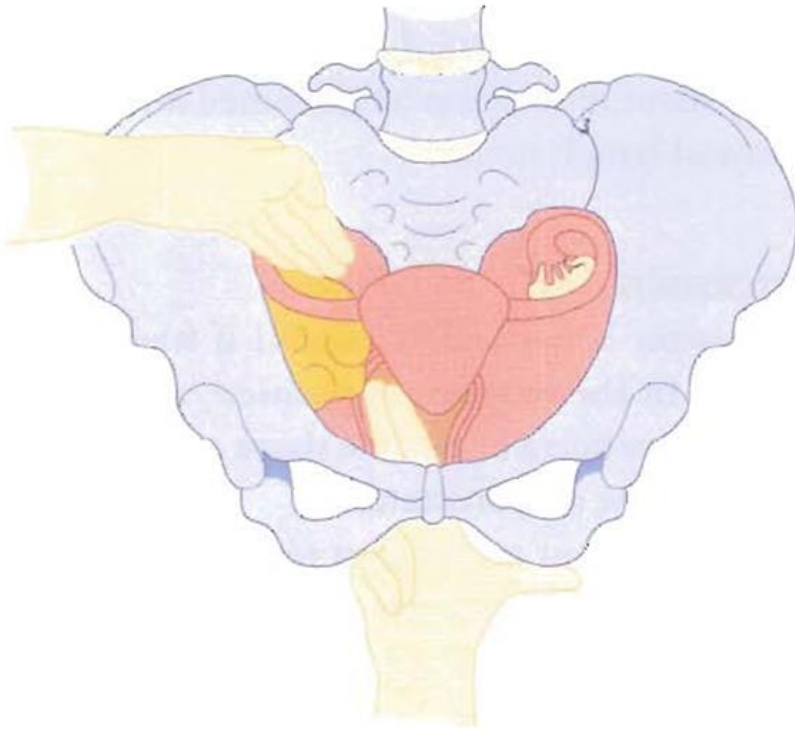
-The fingers are now removed from the vagina.

-Clean the vulva, cover and help the patient to sit up.

-Thank her and make her comfortable.

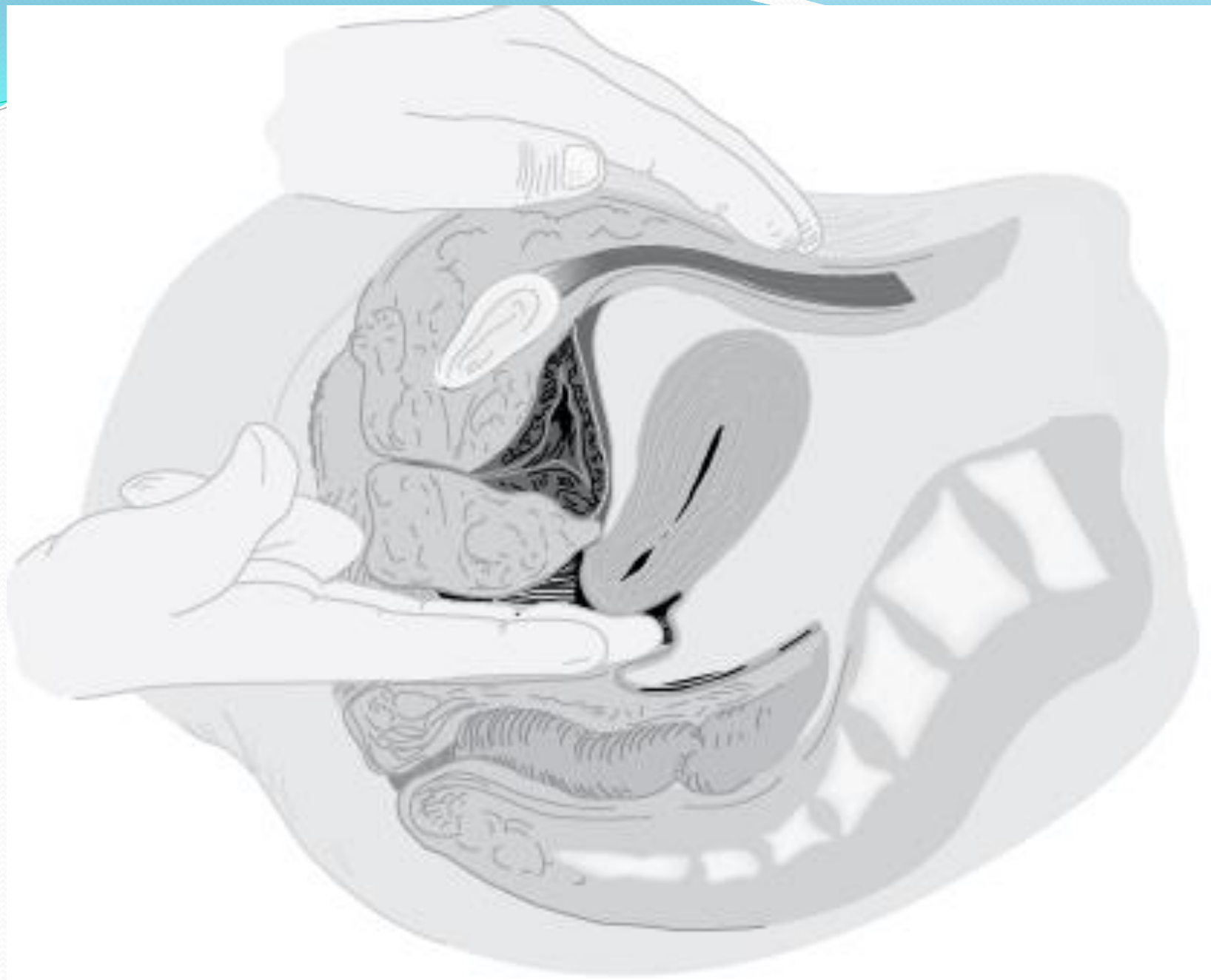


(a)



(b)

Figure 1.4 (a) Bimanual examination of the pelvis, assessing uterine size. (b) Examining the lateral fornix.



In a virgin or a child, only rectal examination should be performed, also useful to differentiate between enterocele and rectocele and could be used to assess the size of a rectocele


Thank you