Clinical Skills Course IV PV examination & Delivery and birth

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PV examination

- Per vaginal examination: The pelvic examination is used to assess the mons, vulva, vagina, cervix, uterus, ovaries, and fallopian tubes .

- **Indications :**

cervical cancer screening and sexually.

transmitted disease (STD) testing.

- **Contraindications:**

Critically unstable patient - medically, emotionally, psychologically

Inavailability of informed consent .

PV examination

- **Equipment:**

gloves

lubricant

- **Positioning:**

lithotomy position

Aske patient for chaperon

PV examination "Procedure" :

- Introduce self, gain consent and co-operation. It is really important that you don't rush this and that you spend time explaining the reasons for bi-manual examination.
- Ensure privacy and dignity is maintained throughout.
- Ensure that the patient has emptied her bladder if necessary, and a urine specimen collected if required
- Give the patient clear instructions as to what clothes will need to be removed i.e. "You will need to remove all clothes from the waist down".
- Ensure that a gown is provided and state that you will return in a few minutes.
- Roll up sleeves, remove watch, wash hands and put on gloves (non sterile).
- Help the patient into the correct position and then tell the patient that you now need to expose her. Ensure that there is adequate lighting.

PV examination "Procedure" :

- Inspect:

Inspect the vulva and perineum noting appearance, any abnormalities, soreness, inflammation, swelling, discharge, warts and any other signs. Labia may require to be parted to ensure adequate exposure of clitoris and urethral meatus

Apply lubrication to your fingers.

Warn the patient that you are about to begin the examination.

- Ask the patient to try and relax, gently insert index and middle fingers, aim for the posterior vaginal fornix. This is in a slightly downward and posterior direction
- Cervix

Palpate the cervix, noting its position, shape, consistency, regularity, mobility and tenderness. Is the internal os open or closed (only open in miscarriage and labour/post partum).

PV examination "Procedure" :

- Uterus

Once you have found the cervix place your fingers behind it so that you can gently push the cervix towards the abdomen. With your other hand start pushing down on the abdomen. Most information is often obtained with this hand. This should then allow you to feel the uterus between your hands. Note the position of the uterus (anteverted / retroverted / axial) and its size and shape. The retroverted uterus can be difficult to find. To help move your fingers anteriorly to the cervix and push down, this brings the uterus up.

- Adnexia

Now move your fingers to the right of the cervix into the right fornix and then push down with the abdominal hand. This will allow you to palpate between your fingers. Try and palpate the right ovary. Note the size, shape, consistency and mobility. (It is frequently not possible to feel the ovary.)

PV examination "Procedure" :

- Palpate for any masses.

Observe your patient as you do this watching for signs of discomfort, tenderness and pain. Repeat the above on the other side

- Cervical excitation

Warn the patient that this might feel strange but should not be painful. Place a finger either side of the cervix. Push the cervix from side to side. This will stretch the pelvic peritoneum. Watch your patients face for signs of pain. The presence of excitation implies peritonism.

Remove your finger and assess the secretion for colour , odor and consistency .

Allow patient to cover up and dress themselves.

Leave clinical area clean and tidy, wash hands.

Delivery and Birth Stage 1

- Introduce self, gain consent and co-operation and ask about contraction pain
- Stage 1 – latent phase – regular uterine contractions becoming stronger and more frequent, cervix thinning (average 10-12 hours)
- Stage 1 – active phase – cervical dilatation from 4cm dilates to 9cm (average 8 hours for first time, 2 hours for previous mothers), or 3-4 regular contractions every 10 minutes, or rupture of membranes
- Stage 1 – deceleration phase (transition) – cervical dilatation at slower pace to 10cm, baby descends lower into pelvis

Delivery and Birth Stage 2

- cervix fully dilated, baby's head fully engaged in the pelvis, mother actively pushes (average 2 hours for first time mothers, 30 mins for previous mothers). Appearance of baby's head at the vaginal opening is called "crowning" - at this point mother may feel intense burning or stinging feeling. The baby's head is usually in the occipito-anterior position so that the baby's face is towards the mother's rectum. The baby's head passes out of the birth canal with the head tilted forwards so that the crown of the head leads the way. The baby's head passes out of the vagina and rotates through 45 degrees to restore normal relationship with the shoulders. The anterior shoulder is delivered followed by posterior shoulder. Baby is born
- During birth, vaginal tears can occur, especially if the baby descends quickly. Tears can involve the perineal skin or extend to the muscles and the anal sphincter and anus. To prevent this, the midwife or doctor can perform an episiotomy (surgical cut to perineum).

Delivery and Birth Stage 2

- Wipe baby clean, wrap in sheets
- Clamp umbilical cord twice (delaying clamping by 1 minute can improve stage 3 outcome). Put clip or tie umbilical cord. Cut the cord between the clamps.

Delivery and Birth Stage 3

- delivery of placenta which can be immediately or after 30 mins. Injection of pitocin, gentle traction on umbilical cord and fundal massage can speed this process
- Three classic signs indicate that the placenta has separated from the uterus:

  (1) The uterus contracts and rises.

  (2) the cord suddenly lengthens .

  (3) a gush of blood occurs.

Encouraging early breastfeeding can be beneficial for both mother and baby and skin to skin contact is important for early bonding

Perform newborn baby check then dress and wrap baby

Leave clinical area clean and tidy, wash hands. Document findings

THANK YOU