HISTORY TAKING AND PHYSICAL EXAM IN GYNECOLOGY

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History taking…….

- History must be taken in a nonjudgmental, sensitive and thorough manner
- Importance must be given towards maintenance of patient-physician relationship.
- Maintain good communication with the patient in order to elicit proper history and to be accurately able to recognize her problems
- Kindness and courtesy must be maintained at all times

- It is important for a male doctor to take history and perform vaginal examination in presence of a female attendant = Chaperone

- Clinician must adopt both an empathetic and inquisitive attitude towards the patient.

- The patient’s privacy must be respected at all costs

- Must refrain from asking personal questions until appropriate patient confidence has been established

- Needs to listen more and talk less while taking the patient’s history

- Must avoid interrupting, commanding and lecturing while taking history

- If any serious condition is suspected, the diagnosis must not be disclosed to the patient until it has been confirmed by performing investigations

- Honest advice and opinion must always be provided.

- Various available treatment options along with their associated advantages and disadvantages must be discussed with the patient to enable her make a right decision

Components of history taking

1. Patient Profile
2. Chief Complaints
3. Menstrual History
4. Obstetric History
5. History of Present illness
6. Past medical history
7. Personal History
8. Family History
9. Socioeconomic history
10. Drugs and allergy history

Patient profile:

- Name
- Age
- Occupation
- Husband’s name,age & occupation
- Marital status
- Address
- Date of admission
- Mode of admission
- Date of examination

Chief Complaints

- Bleeding Per Vaginum/Abnormal Menstrual Bleeding
- Discharge per vaginum
- Mass per abdomen
- Abdominal Pain
- Amenorrhoea
- Unable to conceive
- Something coming out per vaginum
- Urinary Problems and Sexual Dysfunction

Menstrual History

- Age of menarche
- Cycle length and regularity
- Days of flow
- Number of pad changed/day
- Passage of clots
- Last menstrual period
- Associated symptoms
  - Lower pain in the abdomen or back pain

Obstetric History

No. date	Year and events	Pregnancy events	Labor delivery	Method of delivery	Puer-perium	Baby weight and sex. Birth asphyxia. Duration of breastfeeding, contraception
1.						
2.						

No. of living children .....Boys.....Girls.....
Health status of the baby .....
Immunization ..... Last child birth .....

Contraceptive History

- Any contraceptive used?
- Husband/wife?
- Type
- Duration
- Any complications faced

History of Present illness

Abnormal uterine bleeding

- Normal cycle of 28 +/- 7 days

  Average duration – 4-5 days

  Average amount – 40-60 ml

- Heavy menstrual bleeding – excessive uterine bleeding in amount(>80 ml or clots) or duration(>7 days) but the cycle is maintained.

➢ Pathology in uterine cavity or uterus(fibroid uterus, infections of uterus)

➢ A significant increase in the amount or duration is considered HMB, even in the normal ranges

- Polymenorrhea – if the cycle is short i.e. <21 days with normal cycle i.e. frequent bleeding.

- Ovarian pathology or pelvic infection
- Hypothalamic pituitary ovarian axis abnormalities
- Endometrial polyp or other endometrial problems
- PID
- Stress of situation

- Menometrorrhagia – no regularity of flow and the cycles are also heavy

- ➢ Lesion in cervical area, vulva or vagina
- Post coital bleeding – spotting after intercourse
- ➢ Carcinoma cervix
- Oligomenorrhoea – cycles are longer i.e. >35 days

Discharge per vaginum

- Onset
- Duration
- Amount – profuse or scanty
- Color – yellowish, greenish, curdy
- If blood stained
- If foul smelling
- Associated fever, itching, urinary symptoms
- Any relationship with menstual cycle
- If on any antibiotics or any topical application
- If a known case of carcinoma of genital tract

- Physiological – leucorrhoea (sexual excitement, ovulation, premenstrual, pregnancy)
- Infective conditions – chlamydia, candida, gardnerella vaginalis, trichomoniasis
- Chronic cervicitis
- Foreign bodies
- Polyp
- Malignancy of genital tract
- Ring pessary (on senile age group)

Mass per abdomen

- Size of the mass
- First noticed? At which site?
- Duration
- Change in size?
- Mode of onset?
- Association with pain, fever
- Presence of other lumps
- Loss of body weight
- Any secondary change
- Anorexia
- Features of pressure effects

Gynaecological causes:

- Pregnancy(reproductive age group)

- Ovarian pathology:
  Non-neoplastic:
  - Follicular cyst
  - Corpus luteum cyst
  - Theca lutein cyst
  - Endometriosis (Chocolate cyst)
  -Neoplastic:
  - Benign ovarian tumor
  - Ovarian carcinoma

Gynaecological causes:

- Pathological condition of fallopian tubes:

  Non neoplastic:

  -Hydrosalpinx

  -Tubo ovarian mass

  Neoplastic:

  -Carcinoma of fallopian tubes

Gynaecological causes:

- Uterine pathology:
  Uterine tumors:
  -**Uterine leiomyoma**
  -Uterine sarcoma
  Non neoplastic:
  -Hematometra
  -Adenomyosis

- Haematoma of broad ligament & parametrium

Pain lower abdomen

- Site
- Onset
- Timing
- Character
- Radiation
- Aggravating factor
- Relieving factor
- Associated features – fever, vomiting, urinary and gastrointestinal symptoms
- Severity

CAUSES

- Gynaecological – mittelschmerz, pelvic inflammatory disease ovarian torsion, ruptured cyst, degeneration of fibroid

- Non gynaecological – appendicitis, UTI, diverticulitis, bowel obstruction, vesical calculus

Amenorrhea

In primary amenorrhea

- No cycles at age of 14 without secondary sexual characteristics or age of 16 with secondary sexual characteristics.
- Thelarche : breast developmet
- Adrenarche : axillary and pubc hair
- Menarche : cycles

- History of infections, especially encephalitis.

Encephalitis and meningitis might have damaged the hypothalamus or pituitary.

- History of (abdominal) operations. Removal of the ovaries because of tumors, cysts or tuboovarian abscesses.

- Age of mother and older sisters at menarche.Late age at menarche is hereditary.

•Chronic (childhood) disease and/or history of major illness in past 3 years. Chronic debilitating disease can lead to anovulation through hypothalamic dysfunction.

•Cyclical abdominal pain. Together with an abdominal mass, this symptom could indicate a transverse vaginal septum or imperforate hymen.

• Sgnificant weight loss.

- Hirsutism. A masculine distribution of body hair (breast, abdomen, face, thighs) and/or severe acne indicate androgen excess and is a symptom of polycystic ovary syndrome.

- Sexual relations (pregnancy). Question the girl sensitively about sex: does she engage in consensual sexual intercourse or is she a victim of sexual violence? Sexually transmitted infections (STIs), including HIV and pregnancy should be excluded.

In secondary amenorrhea

- Cessation of menstruation for 3 months if previously regular or 6 months if previously irregular.
- Duration of amenorrhea and history of previous cycles. At what age did menarche start? Did the woman have a regular menstrual cycle (21–35days) or was it irregular (<21 days or >35 days)?

How long has she not menstruated?

- History of contraception use after delivery, after how long? What type has she used?

•History of pelvic inflammatory disease (PID) and STIs. Infection of the uterus can cause intrauterine adhesions and endometrial destruction.

- History of severe blood loss or shock after delivery.Pituitary necrosis due to severe postpartum hemorrhage (Sheehan syndrome) may be followed by amenorrhea.

- Breastfeeding (Exclusive) breastfeeding causes lactational amenorrhea for 6 months by suppressing the production of LH and FSH by high levels of prolactin.

- Operations: dilation & curettage, abdominal operations including caesarean section. These operations can lead to intrauterine adhesions or cervical stenosis/adhesions.

Prolapse/*Something coming out per vaginum*

History of:

- Something coming out per vaginum
- Backache or dragging pain in the pelvis
- Dyspareunia
- Urinary symptoms
- Bowel symptom-Difficulty in passing stool
- Excessive white or blood-stained discharge per vaginum-associated vaginitis.

Increased intra abdominal pressure

- Chronic cough due to Smoking, COPD, Asthma etc
- Lifting heavy weight
- Squatting posture
- Constipation
- Intra abdominal tumor
- Ascites
- Increase in uterine volume

General condition

- Malnutrition
- Anemia
- Connective tissue disorder
- Obesity
- Menopause – lack of hormones causing atrophy and weakness of ligaments

Obstetrics history

- Multiparity
- Home or institutional delivery
- Mismanagement of 2nd and 3rd stage of labour
- Prolong and obstructed labour
- Antenatal and post partum pelvic floor exercises

Urinary Problems and Sexual Dysfunction

- Difficulty in passing urine
- Frequent desire to pass urine.
- Urgency
- Frequency
- Painful micturition
- Stress incontinence-precipitated by coughing/sneezing/straining
- Urge incontinence-voiding prematurely before reaching toilet when bladder is full
- Retention of urine
- Painful coitus = dyspareunia

Past medical history

- Diabetes, hypertension, Tuberculosis, hepatitis should be asked.
- longstanding diabetes :- genital candidiasis and associated pruritus.
- History of severe anemia.
- Triad of diabetes, hypertension and obesity is risk of endometrial carcinoma.

- Endocrinological disorders produces menstrual irregularities. Thyroid, prolactin
- Sexually transmitted disease may have a direct bearing on future infertility.
- Previous history of PID or puerperal sepsis produces complaints like menstrual disturbances, lower abdominal pain, and infertility.

Past surgical history

- Cesarean section, removal of appendix, excision of ovarian cyst, myomectomy, etc.
- These make any subsequent surgery difficult, also cause pelvic and abdominal pain, infertility, menstrual disturbances and dyspareunia

Personal History

- Dietary habit
- Sleep pattern
- Bowel habit
- Bladder habit
- Drinking alcohol
- Smoking

Family history

Cancer ovary, uterus and breast have a genetic predisposition.

Menstrual patterns :

- age of menarche
- regularity of cycle,
- associated dysmenorrhea
- age of attaining menopause tend to be similar amongst the family members.

Socioeconomic History

- Family Type, Income
- Type of house
- Sanitation
- Drinking water, toilet facilities

Drug and allergy history

- Allergy to any drug, food or chemical substance

THE GYNAECOLOGICAL 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, demeanour, 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

ABDOMINAL EXAMINATION

Ensure patient lying supine, with a pillow for head rest, arms by the sides and bladder emptied.

- **Inspection:** Assess for distension, scars (operative, traumatic or scarification), distended veins, striae, pubic hair distribution.
- **Palpation:** Palpate the abdomen systematically in all 9 regions

1) Superficial palpation- assess for tenderness, guarding and rebound tenderness
2) Deep palpation- assess any enlargement of intra-abdominal organs (uterus, liver, spleen etc) and for any abnormal masses.

Describe any abnormal mass in terms of:

Size, shape

Position- e.g central arising out of the pelvis, or left iliac fossa

Mobility- e.g can it move from side-to-side and up-and-down or is it fixed to surrounding structures?

Surface - e.g smooth or nodular

Consistency - e.g solid or cystic

Tenderness (pain on palpation)

- **Percussion:** Assess for ascites using shifting dullness and fluid thrill
- **Auscultation:** Listen for bowel sounds or for foetal heart rate in pregnancy

PELVIC EXAMINATION

- Bear in mind the comments on privacy, respect and a female chaperone before this examination is performed.
- Best performed with patient supine in the lithotomy position (legs up in stirrups) and examiner working from the foot of the bed.
- The examination can also be done on an examination couch with patient supine, knees and hips flexed, hips abducted and feet together .The examiner stands on the patient's right side.
- A good and adjustable light source needed for inspection of the vulva and for the speculum examination.
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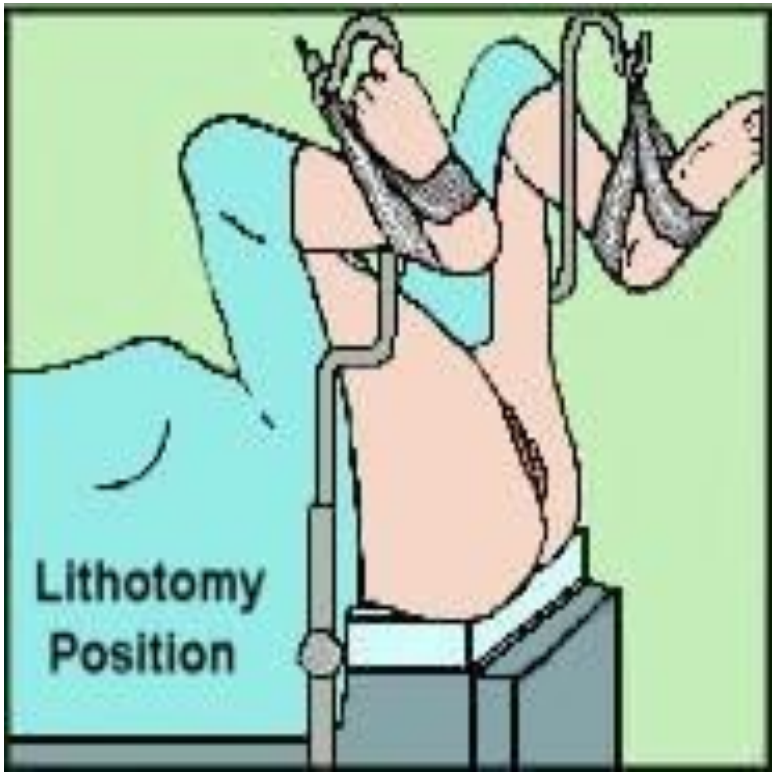
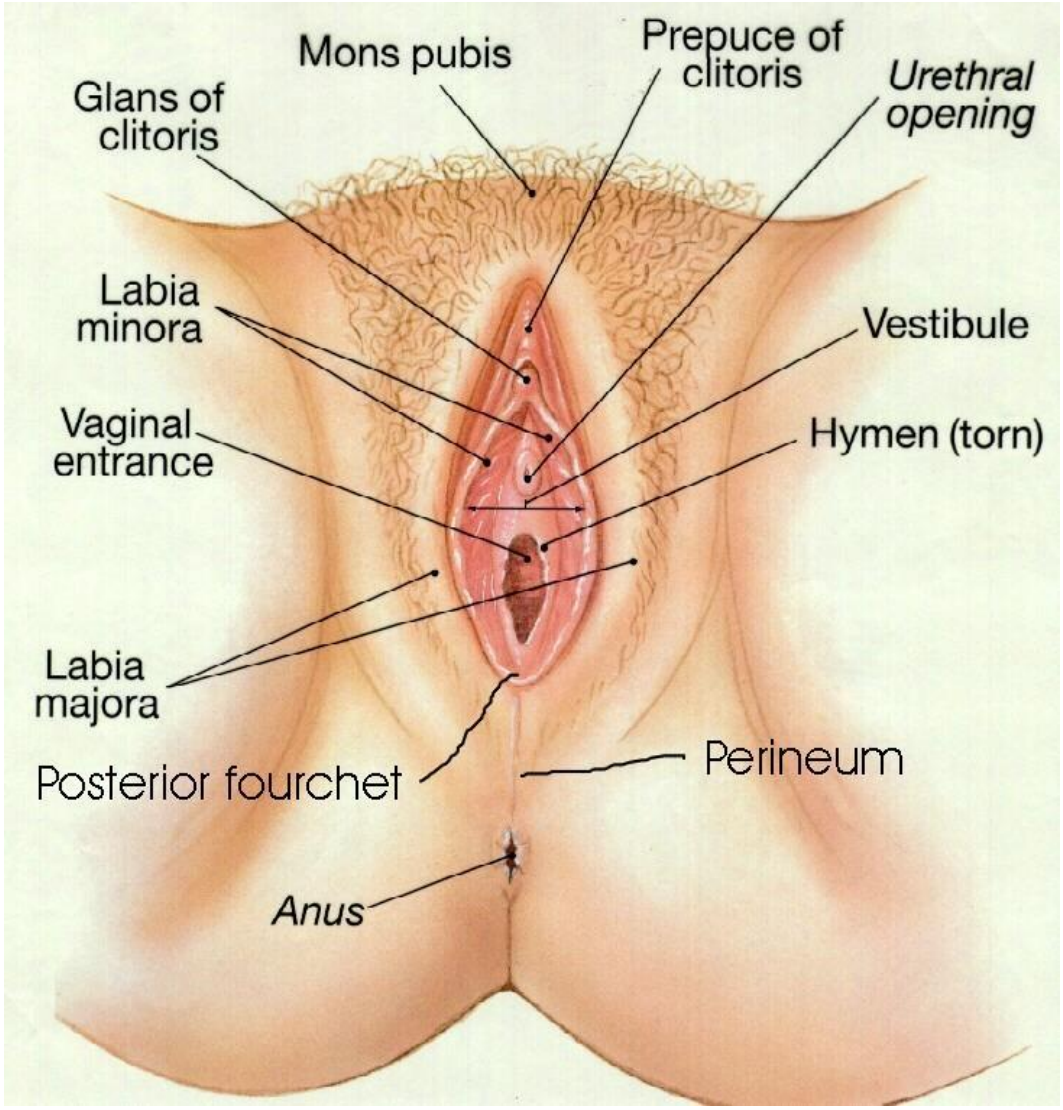


PELVIC EXAMINATION

- Inspection and palpation of the vulva
- Speculum examination
- Bimanual digital examination

FEMALE EXTERNAL GENITALIA



INSPECTION AND PALPATION OF VULVA

Assess all structures from anterior to posterior:

1) **Mons pubis-** Describe pubic hair distribution

   Female pattern-upside down triangle

   Male pattern- diamond shaped

   Look for skin lesions, discolouration, excoriation, lice, ulcers and abscesses

2) **Labia majora - l**ateral to the introitus (opening of vagina), covered with pubic hair. They meet anteriorly as the mons pubis.

INSPECTION AND PALPATION OF VULVA

3) **Labia minora-** Medial to labia majora with no pubic hair covering. They meet anteriorly to cover the clitoris.

   Palpate deep to the labia for enlargement of the Bartholin's gland.

4) **The perineum -** area between the fourchette and the anus (The labia minora meet posteriorly at the fourchette.)

   Inspect for lesions, scars, old third degree perineal tears.

INSPECTION AND PALPATION OF VULVA

5) **The introitus -** Separate the labia minora to expose the introitus, or vaginal opening.

Examine from anterior to posterior

- Inspect the clitoris (size, trauma, ulcers)
- External urethral meatus (discharge, prolapse) and 2 paraurethral gland openings at 3 and 9 o'clock.
- Remnants of the hymenal ring below.
- Vaginal canal - Vaginal mucosa

Well-oestrogenised - pink colour, thick texture and rugae (folds) present.

Poorly oestrogenised - thin, pale colour and absent rugae

- Vaginal discharge- colour, texture, odour
- Older women- ask to cough to demonstrate urinary incontinence or utero-vaginal prolapse

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)

TECHNIQUE OF SPECULUM INSERTION

- Inform patient and ask her to gently bear down while speculum is passed, to relax the levator ani muscles.
- The labia are separated with the index finger and thumb of left hand.
- The lubricated closed speculum (correct size) is inserted through the introitus into the vaginal canal in one of the following ways:

  Nulliparous, young woman: closed speculum blades inserted vertically with speculum handles on patients right side. Rotate through 45 degrees, bringing the speculum handles to the posterior position if using lithotomy position, or the anterior position if using the examination couch.

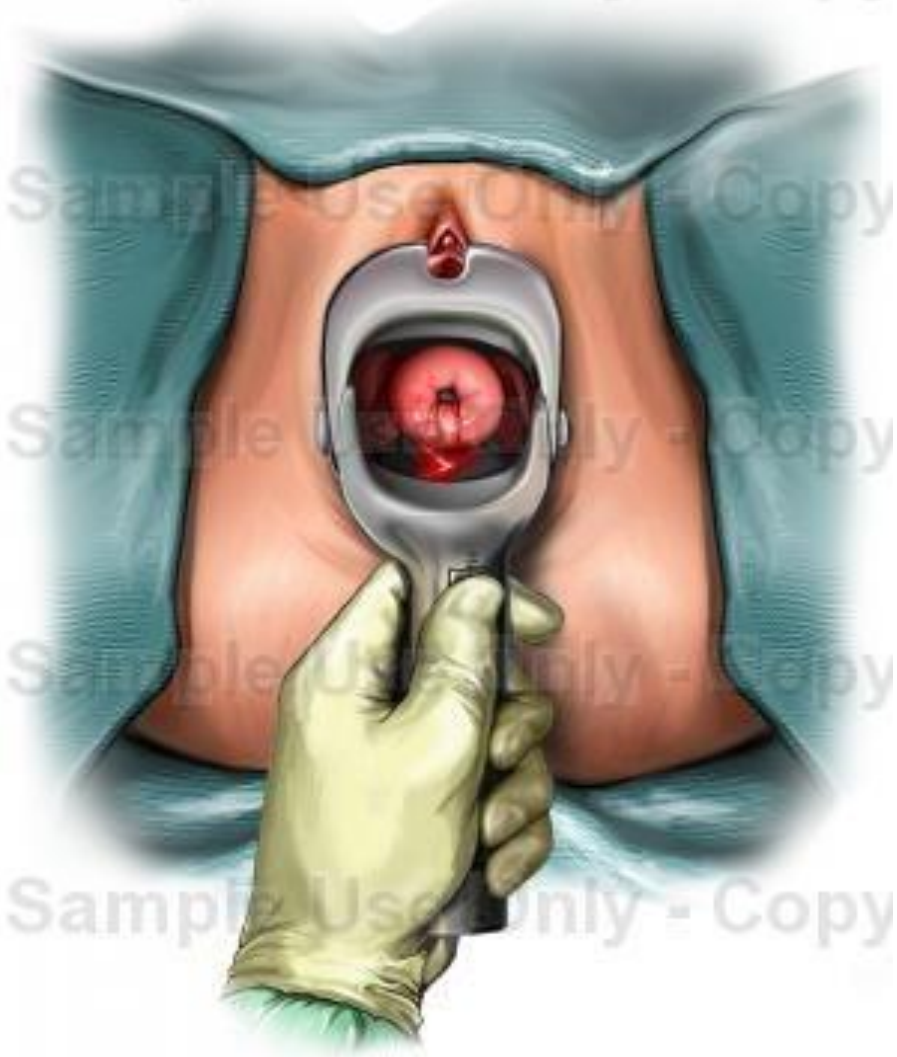
  Multiparous women: The introitus is more patulous as they have given birth previously. The speculum may be inserted without any rotation i.e. closed blades are horizontal with speculum handles pointing posteriorly in the lithotomy position or anteriorly if using the examination couch.

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:

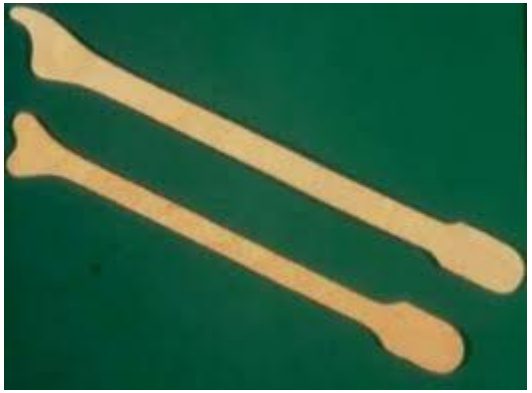
Cervical cancer screening-

-Within 3 years of becoming sexually active or 25 y/o (UK) or 21 y/o (USA), every 3 years till age of 50 and every 5 years till age of 65.

Post-coital bleeding

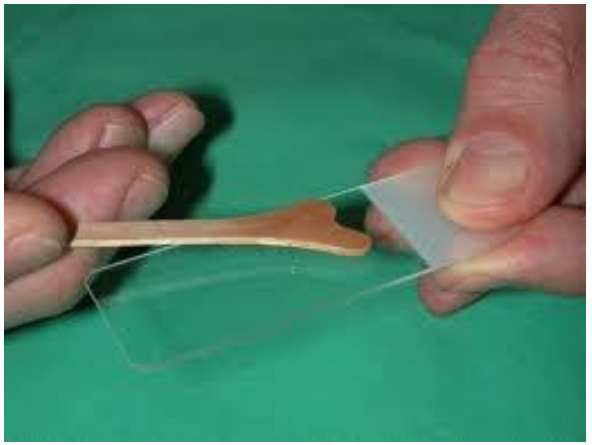
Postmenopausal bleeding

1st trimester of pregnancy



Additional equipment required

- Spatula and endocervical brush
- Swabs
- Fixative spray
- Two glass slides labeled with patient's name

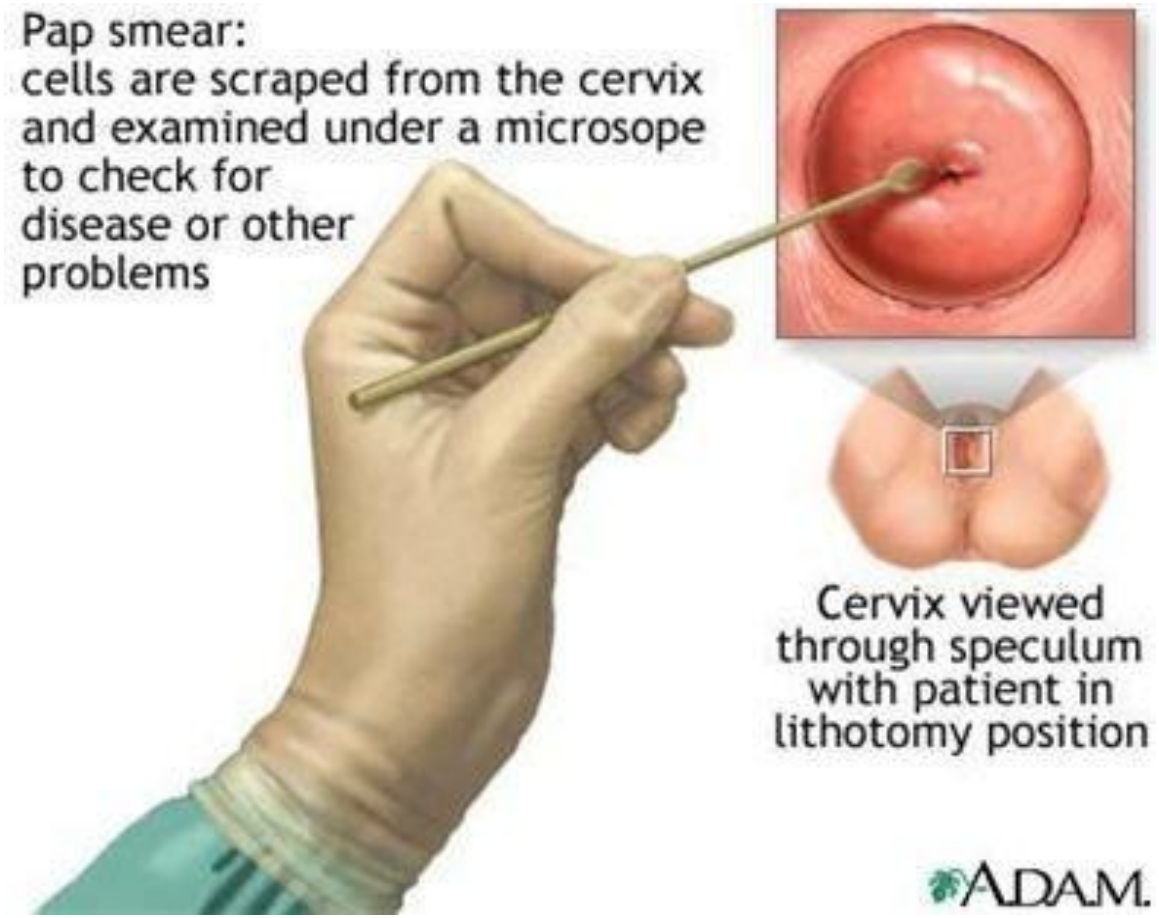


PAP SMEAR

Procedure (Pap smear):

- Gently clean discharge or blood from the cervix, if present, with a cotton swab.
- Insert the spatula with the endocervical tip (the longest part), into the endocervical canal and turn 360 degrees. This allows removal of the surface cells from the whole of the squamocolumnar junction. Apply the smear onto the slide – 2 strokes.
- The brush is superior to the spatula if the transition zone is high and you cannot see it. Turn it gently in five complete circles and apply the smear to the slide in gentle strokes.
- Within 20 seconds of taking it, apply the smear onto the glass slide with a light sweeping motions. Spray immediately with one spray of fixative, holding the spray bottle upright at about 30cm from the slide, to prevent drying and decay of the cells.
- Complete the pathology request form, recording any findings about the appearance of the cervix and send the smear to the laboratory.
- It is crucial to contact the patient with the results, hence ensure her address and contact tel. nos are complete and correct.

PAP SMEAR


Pap smear:
cells are scraped from the cervix and examined under a microsope to check for disease or other problems
Cervix viewed through speculum with patient in lithotomy position
A.D.A.M.

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.

BIMANUAL DIGITAL EXAMINATION

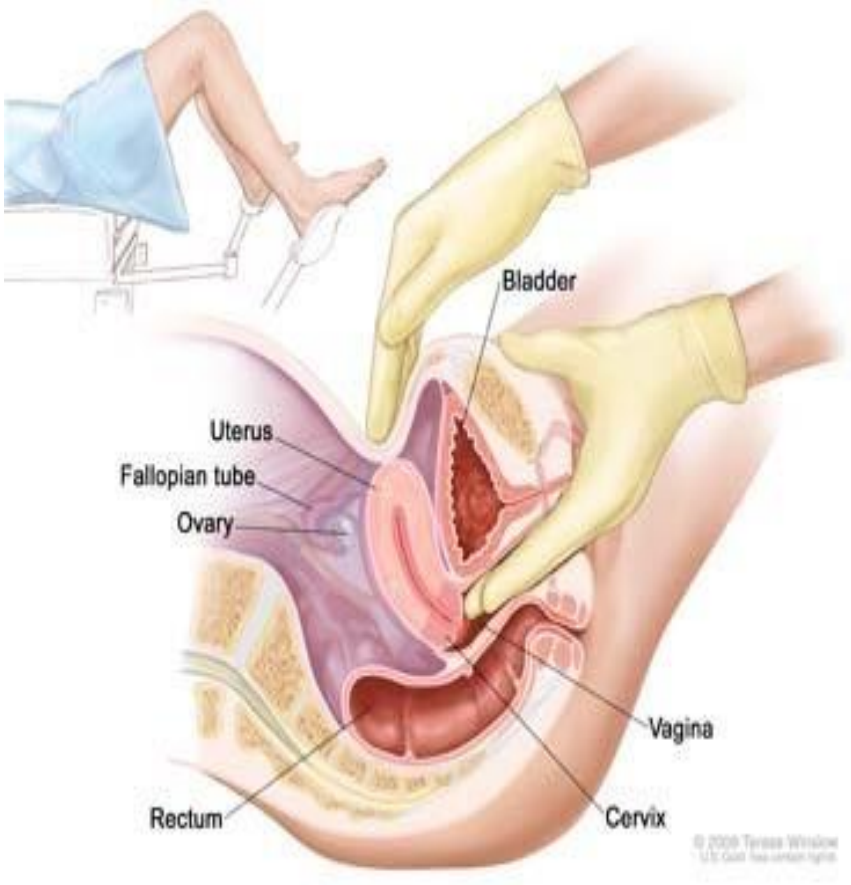
- Explain every step to the patient and reassure her - inform her that an internal examination is to be performed.
- The labia are gently parted with the gloved index finger and thumb of the left hand.
- The full length of the fingers is introduced after putting lubricant gelly, assessing the vaginal walls in transit until the cervix is located.

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 o**f 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 and ectopic pregnancy.



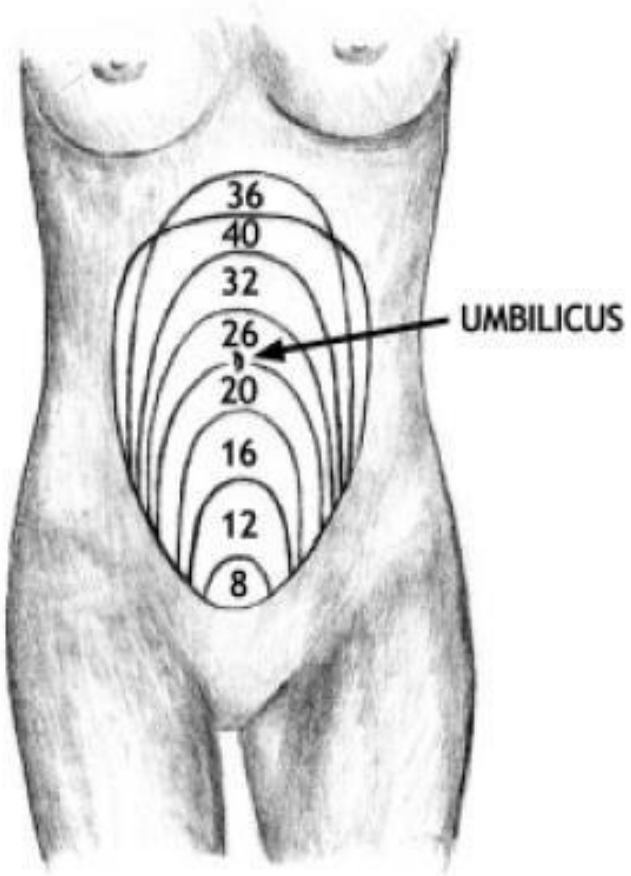
BIMANUAL DIGITAL EXAMINATION

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.

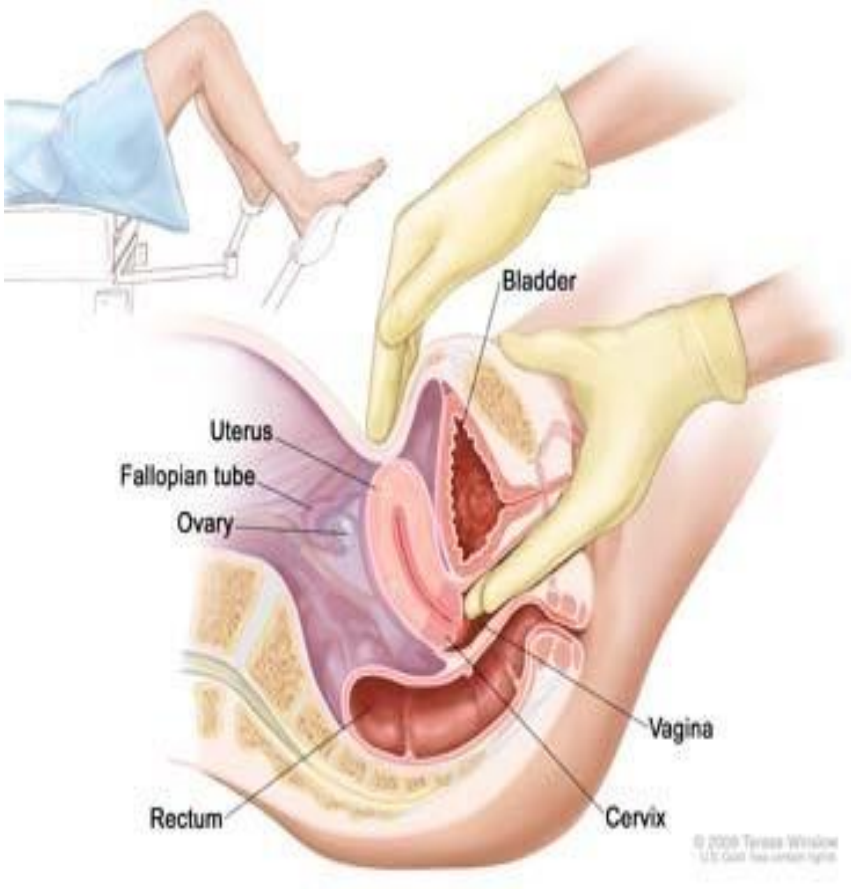


BIMANUAL DIGITAL EXAMINATION

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.

Record your findings in the chart

- Vaginal examination – often abbreviated as PV (per vaginum) or VE (vaginal examination)
- Describe each of the following, plus any abnormalities noted:
- **Vulva and vagina**
- **Cervix**
- **Uterus**
- **Adnexae**
- **Any additional significant findings**

Example – for a routine check-up may see notes recorded as follows:

PV: V&V: NAD

Cervix: Closed, non-tender, no visible abnormality (Pap taken)

Uterus: Bulky, non-tender, approximately 6 week size

Adnexae: NAD


THANK YOU