

1

History taking and physical examination

Figure 1.1 LEOPOLD MANEUVERS

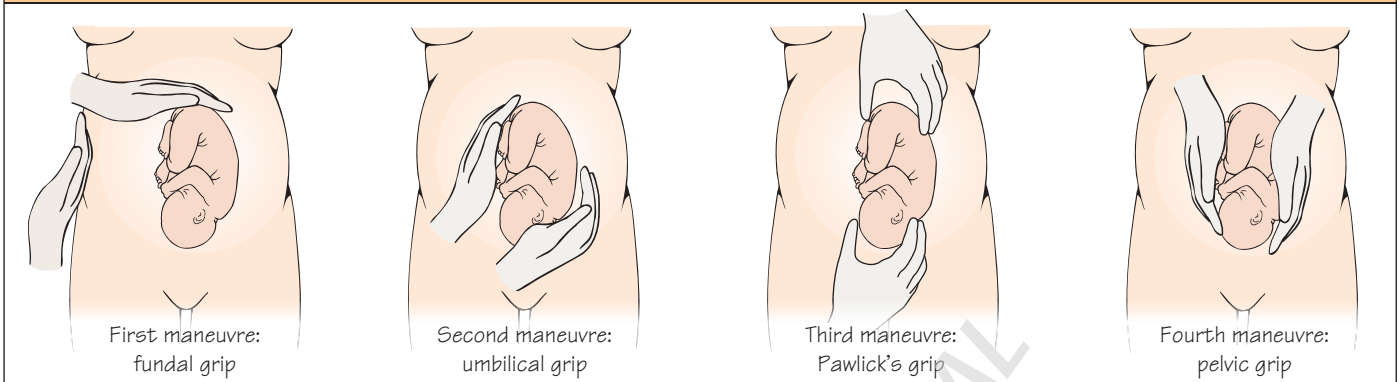


Figure 1.2 SPECULA FOR GYNECOLOGIC EXAMINATION

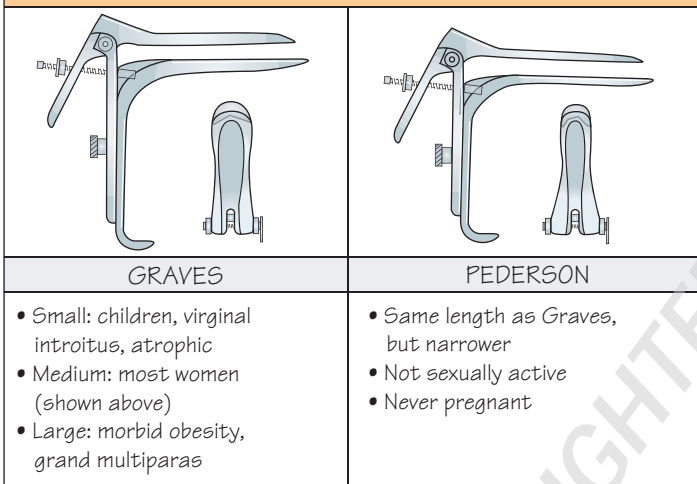


Figure 1.3 PERFORMING A PAP SMEAR

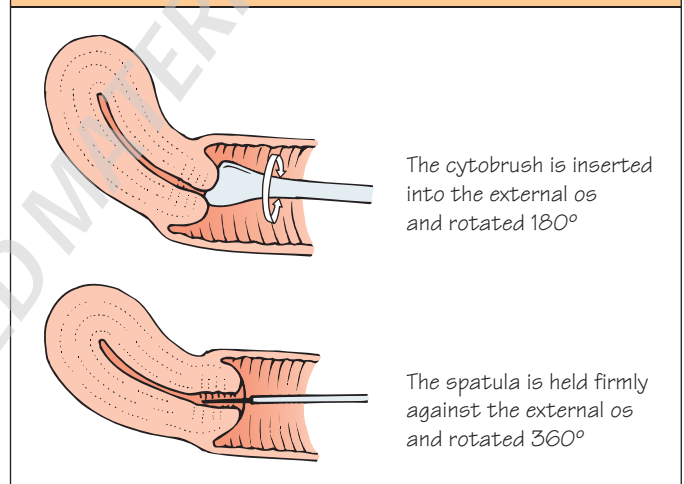
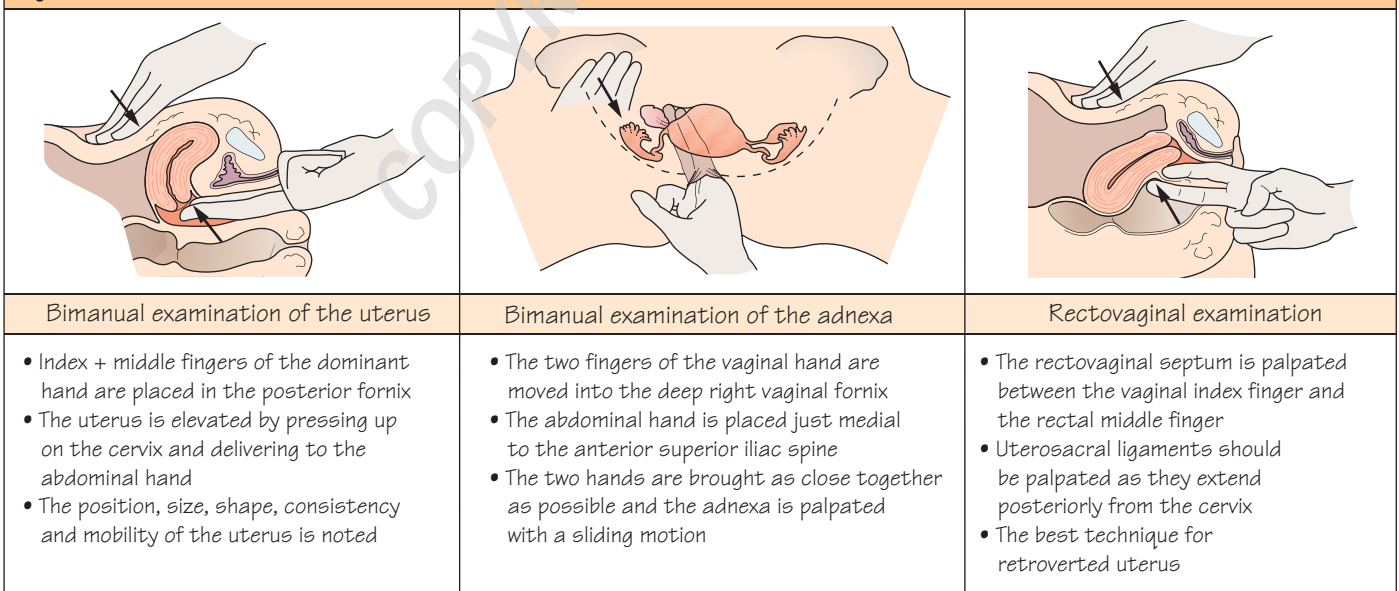


Figure 1.4 PELVIC EXAMINATION



General comments

- Dress appropriately and conduct yourself in a professional manner. Smile whenever appropriate and try to focus on putting the patient at ease.
- Introduce yourself by name and explain your role. Be welcoming to anyone else who may be with the patient. If you have other members of your team, introduce them as well.
- Begin by taking a brief history and trying to establish rapport before asking the patient to undress for her physical examination. Sit facing her and make direct eye contact.
- Listen carefully and invite questions to foster a trusting relationship. Try to understand the problem from her point of view in order to develop the most effective management plan. Acknowledge important points in the history by verbal or non-verbal cues (nodding).
- Occasionally, sensitivity to cultural expectations will require a change in approach. For example, some cultures discourage shaking hands whereas in others the husband or male family members will answer questions directed at the woman.

History

Taking an effective history involves a complicated interplay of multiple conflicting issues. The physician must create a comfortable environment, not appear rushed, and listen to all concerns, but at the same time stay focused and put limits on his or her time. The interview should be comprehensive, but tailored appropriately.

- **Chief complaint.** Patients should be encouraged to express, in their own words, the main purpose of the visit.
- **Present illness.** Pertinent open-ended questions can help clarify the details of the chief complaint and provide additional perspective.
- **Past medical and surgical history.** All significant health problems should be noted and any recent changes explored in more detail if indicated. Patients should be asked for an updated list of current medications and allergies. Prior surgical procedures, especially any involving the abdomen, pelvis, or reproductive organs, should be documented.
- **Gynecologic history.** Age-appropriate questions may include a detailed menstrual history (age of menarche or menopause, cycle length and duration, last menstrual period), contraceptive usage, prior vaginal or pelvic infections, and sexual history.
- **Obstetric history.** The number of pregnancies and their outcome should be detailed, including gestational ages, pregnancy-related complications, and other information if applicable to the visit.
- **Family history.** Serious illnesses (diabetes, cardiovascular disease, hypertension) of affected family members, particularly first-degree relatives, may have implications for the patient.
- **Social history.** To provide some context, questions should be asked about her occupation and where and with whom she lives. Patients should also routinely be asked about cigarette smoking, illicit drug use, and alcohol use.
- **Review of systems.** Consistently inquiring about the presence of physical symptoms is invaluable to uncover seemingly (to the patient) innocuous aspects of her health. Areas of importance include: constitutional (weight loss or gain, hot flashes), cardiovascular (chest pain, shortness of breath), gastrointestinal (“irritable bowel syndrome,” constipation), genitourinary (incontinence, hematuria), neurologic (numbness, decreased sensation), psychiatric (depression, suicidal ideations), and other body systems.

Physical examination

1 General examination

- The patient should be asked to disrobe for a complete physical examination. Before discreetly stepping out of the room, it is the

physician’s responsibility to provide an appropriate gown and to assuage any anxiety by explaining what the examination will involve.

- A female chaperone should be present during the examination, regardless of physician gender.
- A comprehensive, but reasonably focused, examination should be conducted to assess her general health and provide insights that may have direct relevance to the chief complaint.

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 four Leopold maneuvers should be performed (Figure 1.1): (1) palpate the woman’s upper abdomen to identify either the fetal head or buttocks; (2) determine location of the fetal back; (3) identify whether fetal head or buttocks is lying above the inlet within the lower abdomen; and (4) locate the fetal brow.

3 Pelvic examination

- The patient should be asked to lie supine on the examining table and place her feet in stirrups.
- **Inspection** of the perineum involves assessment of the hair pattern, skin, presence of lesions (vesicles, warts), evidence of trauma, hemorrhoids, 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 maneuver).
- **Speculum examination** begins by choosing the appropriate type and size of speculum (Figure 1.2), inserting the blades through the introitus and guiding the tip in a downward motion toward the rectum. The blades are 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** (Figure 1.3) samples the transformation zone of the cervix (the junction of the squamous cells lining the vagina and the columnar cells lining the endocervical canal).
- **Bimanual examination** (Figure 1.4) 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 pear). A normal ovary is approximately 3 × 2 cm in size, but is often not palpable in obese or postmenopausal women.
- **Rectovaginal examination** (Figure 1.4) is especially valuable when pelvic organs are positioned in the posterior cul-de-sac, in preoperative planning, and in assessment of gynecologic cancers.
- **Rectal examination** performed separately and circumferentially with the examining finger can rule out distally located colorectal cancers. The physician may also note the tone of the anal sphincter and any other abnormalities (hemorrhoids, fissures, masses), and test a stool sample for occult blood.

Screening tests and preventive health

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