CHAPTER 1

The history and examination in gynaecology

The remit of the doctor is to improve quality of life, not just to treat life-threatening disease: if a symptom is causing distress, treatment should be considered. The type and extent of treament are determined largely by the patient; the doctor gives information and advice, so the patient can give her *informed* consent. The patient's history should be used not only to help make a diagnosis but also to discover how much her symptom(s) is/are affecting her. Or she may simply be cocerned as to the cause of her symptoms (e.g. malignancy) and reassurance is enough.

The gynaecological history

Personal details

Ask her name, age and occupation.

Presenting complaint(s)

How long has the problem been present and how much does it affect her? If it is pain, what alleviates and what exacerbates it, where is it and what is its nature? Allow the patient to elaborate as there may be more than one problem, initially without asking direct questions, perhaps asking her to rate her problems in order of severity. Has she ever consulted a doctor about this problem before and, if so, what has been done? If there are multiple presenting complaints, these should be put in order of severity/effect on her life.

Specific gynaecological questions

These are asked next, starting with ones that are relevant to this presenting complaint. For example, if it is a menstrual problem, the most appropriate next questions concern menstruation; if it is a urinary problem, one should ask all the appropriate urinary tract questions next.

Menstrual questions: How often does she menstruate (how many days from the first day of bleeding to the next first day?) and how long does menstruation last? (4/28 means bleeding lasts for 4 days and occurs every 28 days.) Is it regular or irregular? Is it heavy? (Number of pads/tampons used or the presence of clots can be useful.) Is it or the days leading up to it painful? Is there ever intermenstrual bleeding (IMB)? Is there ever postcoital bleeding (PCB)? Is there ever vaginal discharge and, if so, what is it like? Does she experience premenstrual tension? When was her last menstrual period (LMP)? If postmenopausal, has there been postmenopausal bleeding (PMB)?

Sexual/contraceptive questions: Is she sexually active? If so, is it painful? If so, is it on penetration (superficial dyspareunia) or deep inside (deep dyspareunia) and is it during and/or after (delayed)? What contraceptive (if appropriate) does she use and what has she used in the past?

Obstetrics & Gynaecology, Fifth Edition. Lawrence Impey, Tim Child.

Cervical smear questions: When was her last cervical smear? (This should be done every 3 years between the ages of 25 and 49 years, every 5 years between 50 and 64 years, and not performed thereafter unless never screened or history of recent abnormal tests.) Has she ever had an abnormal smear? If so, what was done?
Urinary/prolapse questions: Does she experience frequency (normal is 4–7 times per day), nocturia (micturition at night) or urgency (a severe desire to void)? Does she ever leak urine, including when asleep (nocturnal enuresis)? If so, how severe is it and with what is it associated (e.g. coughing, lifting/straining or urgency)? Is there ever dysuria (pain on micturition) or haematuria (blood in the urine)? Does she ever get a dragging sensation or feel a mass in or at the vagina?

Menstrual questions

How often and for how long?
Heavy or painful?
Regularity?
Intermenstrual bleeding (IMB) or postcoital bleeding (PCB)?
When was her last menstrual period (LMP)?

Other history

Past obstetric history: This should be brief. Start with 'Have you ever been pregnant?' If the answer is 'No', go on to past medical history. If 'Yes', ask for details about previous pregnancies in chronological order. See Chapter 16 for explanation of parity and gravidity. Of deliveries, ask when, what weight, how was the infant born and how the infant is now. Ask about any major complications in the pregnancy or labour.
Past medical history: First ask about any previous, particularly gynaecological, operations, however distant. Then directly ask about venous thrombosis, diabetes, lung and heart disease, hypertension, jaundice, etc. as in any medical history. If you elicit no significant history, ask 'Have you ever been in hospital?'
Systems review: Ask the usual cardiovascular, respiratory and neurological questions. In particular, ask about urinary and gastrointestinal symptoms in view of the close pelvic relationship.
Drugs: Does she take any regular medication including prescribed, over-the-counter or complementary? Consider asking about illegal drug use if relevant.
Family history: Is there a family history of breast or ovarian carcinoma, of diabetes, venous thromboembolism, heart disease or hypertension?
Personal/social history: Does she smoke? Does she drink alcohol? If either, how much? Is she married or in a stable relationship and, if not, is there support at home? Where does she live and what sort of accommodation is it?
Allergies: Ask specifically about penicillin and latex.

Presenting the history

Start by summing up the important points, including relevant gynaecological questions:
This is . . . , who is a . . . year-old . . . (parity), with a . . . (time) history of . . . , who . . . (most significant findings in history).

Example: This is Mrs X, who is a 38-year-old nulliparous woman, with a 3-month history of postcoital bleeding (PCB), who has a normal menstrual cycle and last had a cervical smear 7 years ago.
N.B. By mentioning the last smear, you have shown understanding that PCB may be a symptom of cervical carcinoma.

Now go through the history in some detail.
Then sum up again, in one sentence.

Gynaecological history: specific essential questions

Presenting complaint, its history
Menstrual questions: last menstrual period (LMP), cycle, flow, intermenstrual bleeding (IMB), postcoital bleeding (PCB)
Urinary/prolapse questions
Sexual/contraceptive questions
Cervical smear history
Past obstetric history

Other questions

Now ask 'Is there anything else you think I ought to know?'. This gives her the opportunity to help you if you have not discovered all the important facts.

Summarizing the history

1 Could the symptoms be a manifestation of underlying disease that needs to be treated? (For example, erratic menstrual bleeding may be a sign of malignancy.)
2 Are the symptoms themselves causing physical damage? (For example, erratic menstrual bleeding may lead to severe anaemia.)
3 Are the symptoms themselves causing distress? (For example, erratic menstrual bleeding may disrupt a woman's life such that she may feel unable to leave the home.) Or is she unconcerned?

The gynaecological examination

General examination

This is to:
1 seek the effects (e.g. secondary spread of malignancy) or, more rarely, the causes (e.g. thyroid abnormalities cause menstrual disturbances) of gynaecological problems
2 assess general health and incidental disease, particularly if an anaesthetic may be needed.
General appearance and weight, temperature, blood pressure and pulse, and possible anaemia, jaundice or lymphadenopathy should be noted. More detailed examination of the rest of the body is often perfunctory in the young, fit patient, but is important in the older or more sick patient, or in those about to have an anaesthetic.

Breast and axillary examination

This can be performed as a screening test for breast cancer, although breast examination is not routinely undertaken in UK gynaecological practice unless investigating a potentially malignant pelvic mass (Fig. 1.1). The patient sits back, the breasts are inspected for irregularities and all four breast quadrants are palpated as the patient lies supine with her hands behind her head. The axilla, a principal area for lymph drainage, is then palpated with the patient's arm resting on the examiner's shoulder.

Abdominal examination

The patient lies comfortably on her back with her head on a pillow, discreetly exposed from the xiphisternum to the symphysis pubis. The bladder should be empty.

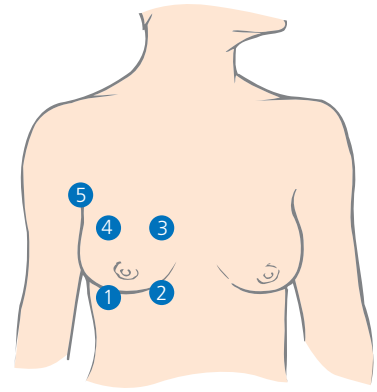

Fig. 1.1 Examination of the breast.

Inspect

Look for scars, particularly just above the symphysis pubis and in the umbilicus. Look at the distribution of body hair, for irregularities, striae and hernias.

Palpate

Ask about tenderness first, then palpate gently around the abdomen looking for masses or tenderness. Then palpate specifically for masses from above the umbilicus down to the symphysis pubis (Fig. 1.2). If any masses are present, do they arise from the pelvis (i.e. can you get below them)?

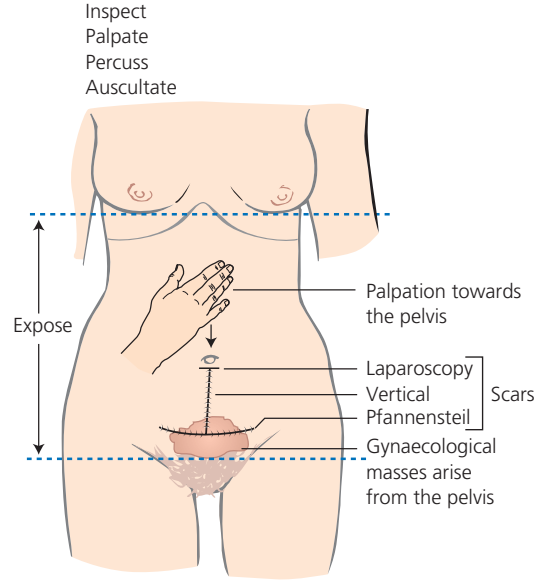

Fig. 1.2 Abdominal examination.

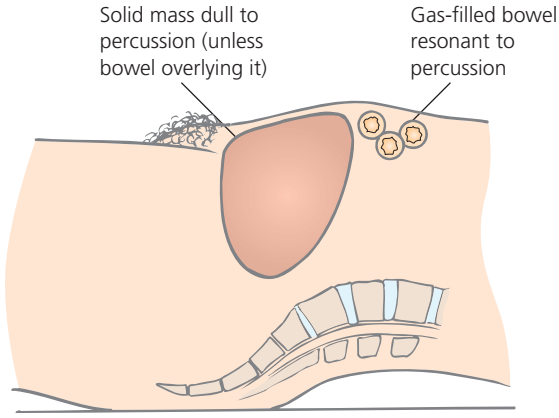

Fig. 1.3 Percussion of the abdomen.

Percuss

Go around the abdomen. The bowel is resonant; fluid-filled and solid cavities (e.g. masses, full bladder) are dull (Fig. 1.3). Look for shifting dullness (free fluid).

Auscultate

Listen to the bowel sounds.

Gynaecological examination
General
(Breast)
Abdomen
Pelvic palpation: digital
Cervical/vaginal inspection: speculum

Vaginal examination

Ensure privacy, explain simply what you intend and ask for the patient's permission. Offer her the opportunity to use the bathroom first. A chaperone must be offered, whether you are male or female, and the presence and name of the chaperone documented in the notes. Use lubricating jelly. A metal speculum should be warmed. Internal examination is often uncomfortable, but severe tenderness is abnormal.

Inspect

The vulva and the vaginal orifice are inspected first. Are there any coloured areas, ulcers or lumps on the vulva? Is a prolapse evident at the introitus? Three types of examination have different purposes.

Digital bimanual examination

This assesses the pelvic organs. The patient lies flat, with her ankles together drawn up towards her buttocks and knees apart. Warn the patient before you touch her and ask her to let you know if she finds the examination too uncomfortable. The left hand is placed on the abdomen above the symphysis pubis and is pushed down into the pelvis, so that the organs are palpated between it and two fingers are gently inserted into the vagina (Fig. 1.4).

The uterus is normally the size and shape of a small pear. Size, consistency, regularity, mobility, anteversion or retroversion and tenderness are assessed.

The cervix is normally the first part of the uterus to be felt vaginally and the os is felt as an opening like a toy car tyre. Is the cervix hard or irregular?

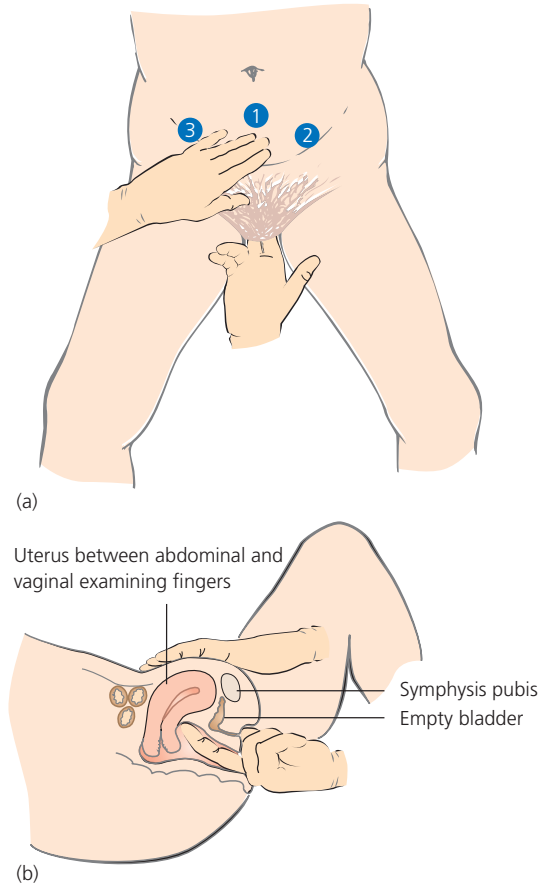

Fig. 1.4 Digital bimanual vaginal examination: (a) bimanually palpate areas 1, 2, 3 in order; (b) digital bimanual palpation of the pelvis.

The adnexa (lateral to the uterus on either side, containing tube and ovary): tenderness and size and consistency of any mass are assessed. Is it separate from the uterus?

The pouch of Douglas (behind the cervix): the uterosacral ligaments should be palpable. Are these even, irregular or tender, or is there a mass?

Cusco's speculum examination

This allows inspection of the cervix and vaginal walls. The patient lies as for the digital examination. With the blades closed and parallel to the labia and the opening mechanism pointing to the patient's right, gently insert the speculum (Fig. 1.5a). Then rotate it 90° anteriorly and insert it as far as it will go without causing discomfort (Fig. 1.5b). Open it slowly under direct vision and the cervix will come into view (Fig. 1.5c). Common mistakes include not inserting the speculum sufficiently deep and/or posterior with an anterverted uterus. The cervix may be very anterior with a retroverted uterus. Look for ulceration, spontaneous bleeding or irregularities. A cervical smear can be taken. Now slightly withdraw the speculum under direct vision and partly close it without catching the cervix. Slowly withdraw it just open, allowing inspection of the vaginal walls to the introitus, and then close the speculum and remove it, rotating the speculum through 90° on the way out.

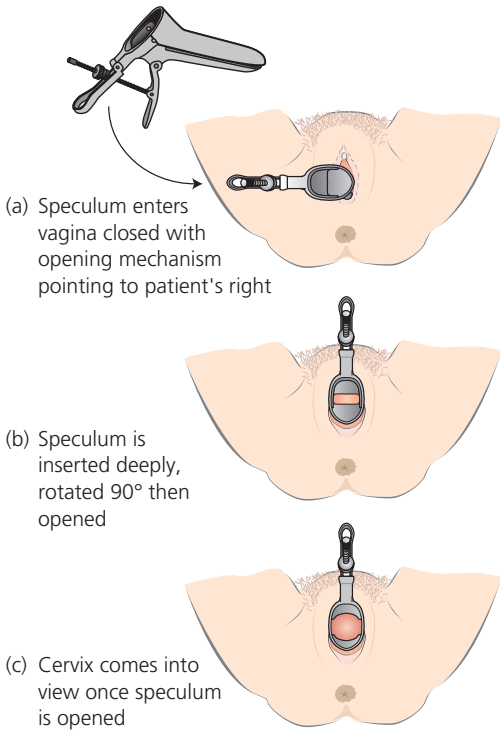

Fig. 1.5 Cusco's speculum examination of the cervix and vaginal walls. (a) Speculum enters vagina closed with opening mechanism pointing to patient's right. (b) Speculum is inserted deep, rotated 90°, then opened. (c) The cervix comes into view once the speculum is opened.

Sims' speculum

This allows better inspection of the vaginal walls and, specifically, the prolapse. The patient should be positioned in the left lateral position with the legs partly curled up. Insert the curved speculum into the vagina from behind, with one end pressing against the posterior wall to allow inspection of the anterior wall. Then reverse the speculum, pressing back the anterior wall so that the posterior wall can be seen (Fig. 1.6). If the patient is asked to bear down, the prolapse of either wall and the cervix or vaginal vault can be assessed.

Rectal examination

This is occasionally appropriate if there is posterior wall prolapse, to distinguish between an enterocoele and a rectocoele, and in assessing malignant cervical disease. It may also be necessary if the woman complains of cyclical rectal bleeding, possibly due to rectovaginal endometriosis.

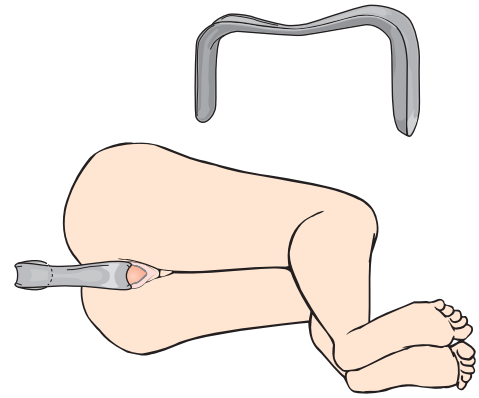

Fig. 1.6 Sims' speculum examination of the vaginal walls.

Presenting the examination

Present the examination findings, including relevant positive or negative findings:

Mrs X is . . . (describe general appearance sensitively), her blood pressure, temperature and pulse are . . . and abdominal and pelvic examination reveals. . . . There is . . . (mention important positive and negative findings).

Example: Mrs X looks thin and clinically anaemic, her blood pressure is 120/60 mmHg, temperature is normal and pulse is 90 beats/min; abdominal examination reveals a mass arising from the pelvis up to the level of the umbilicus, with no obvious ascites. There is no lymphadenopathy or breast abnormality.

N.B. By mentioning ascites, lymphadenopathy and the breasts, you demonstrate your understanding of the possible aetiology and effects of a pelvic mass.

Management plan. Now decide on a course of action. Plan what investigations (if any) are needed and what course of action (if any) is most appropriate.

Gynaecological history at a glance

Personal details	Name, age, occupation	
Presenting complaint	Details, time-scale, any previous treatment. Prioritize	
Gynaecological questions	(Start with most relevant to complaint)	
	Menstrual:	Last menstrual period (LMP), cycle, heaviness, intermenstrual bleeding (IMB), postcoital bleeding (PCB)
	Sex/contraceptive:	Sexually active, dyspareunia, contraception?
	Cervical smear:	Last smear, ever abnormal?
	Urinary/prolapse	Frequency, incontinence, lump at introitus
Other history	Past obstetric history:	Ever pregnant? If so, details
	Past medical history:	Operations, major illnesses. Ever in hospital?
	Systems review, drugs, personal (smoking, alcohol), social, family history (particularly breast/ovarian/heart disease), allergies	
Summarize	Presenting complaint and relevant history findings	

Gynaecological examination at a glance

General	Appearance, anaemia, lymph nodes, blood pressure, pulse
(Breasts/axillae)	Inspect, palpate
Abdomen	Inspect, palpate (particularly suprapubically), percuss, auscultate
Vaginal	Inspect vulva; digital examination; Cusco's speculum, Sims' speculum if prolapse
Summarize	Positive and important negative findings; consider management