GYNAECOLOGY HISTORY AND EXAMINATION

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Objectives

- At the end of this session the student will be able to:
  - Describe essential components of GYN history
  - List major gynecological symptoms
  - Describe essential components of gynaecological examination

Gynecology History

- Biodata
- Presenting complaint (s) / chief complaints and duration
  - In patient's own words
- History of presenting complaints
  - the sequence of symptoms as told by the patient is crucial in making a diagnosis

Symptoms	Sudden onset /short duration causes	Insidious onset /long duration causes
PAIN / Exact site and radiation /Intensity - work and sleep	PID, STIs, early pregnancy complications (PDT, US-TVS), , UTI (h/o MSSU-MCS), ovarian, appendicitis	PID ± infertility- galactorrhea Benign-myomas, ovarian, endometriosis, malignant - uterine: Cx, endometrial, ovarian: **WEIGHT LOSS and malignancy, somatization-anxiety**
BLEEDING: vaginal/rectal Normal / physiological vs. abnormal	PID, STIs, early pregnancy complications (PDT), UTI,	Benign-myomas, ±ovarian; Malignant-uterine: Cx-PCB, endometrial, ±ovarian;postmenopause: **atrophic vaginitis, WEIGHT LOSS and malignancy, somatization-anxiety**
Abnormal	Reproductive age: Irregular, inter-, pre- post menstrual (spotting, light), heavy bleeding (menorrhagia) Post menopausal age: PMB V	

Symptoms	Sudden onset /short duration causes	Insidious onset /long duration causes
VAGINAL DISCHARGE: (a) Normal vs. abnormal : speculum exam necessary & digital exam preferred (b) Recurrent /blood stained: fails to respond to treatment.	Candidiasis-curdy like / pruritus: pregnancy, hormonal FP, hygiene, immune disturbances PID, STIs, h/o swabs for culture	Infection: PID; Benign-myomas, ovarian; Malignant-uterine: Cx-PCB, cervical smear; endometrial, postmenopause: **WEIGHT LOSS and malignany**
ABDOMINAL SWELLING	R/O pregnancy, intestinal obstruction, peritonitis,	Benign-myomas, ovarian; Malignant-uterine: Cx-PCB, endometrial, ovarian: **WEIGHT LOSS**

Symptoms	Sudden onset /short duration causes	Insidious onset /long duration causes
Urinary / faecal incontinence	(a) fluid leaking or flowing out of your vagina uncontrollably following difficult labour± foul smell: VVF: **OBSTETRIC FISTULA**	(a) leaking of urine or a chronic urge to urinate worsened by increased intraabdominal pressure-pelvic organ prolapse:
Failure to conceive	If patient of reproductive age, sexually active, trying conceive and have unprotected, regular intercourse for 12 months or longer by definition, is infertile; patients may present with surrogate symptoms such as lower abdominal pain or abnormal vaginal bleeding (Ideally both partners should be seen together):	
Severity; Relationships to: menstruation, coitus, micturition, other gynae. & constitutional symptoms		

- Past medical / surgical history, family history, drug history, social history, menstrual history, STIs, contraceptive history & sexual history
- Summary of Obs/Gynae history: summary of pregnancies: **Parity: Para 0 +º, Para 2+[1], number of living children and date of last delivery**

SYSTEMIC ENQUIRY

- CNS: fever, headaches, dizziness, syncope, visual disturbances, convulsions: ? cause
- Cardiovascular system: palpitations, easy fatigability : ? cause
- Respiratory system: SOB, chest pain: ? cause
- Urinary system symptoms: : ? cause
- GIT system: bloated, flatulence, jaundice, constipation, diarrhoea: ? cause
- Musculoskeletal system: pain / unibilateral, oedema : ? cause

Summary

- Symptoms: Systematic characterization of the nature and duration of complaints as ***pain, abnormal bleeding / vaginal discharge, abdominal swelling, urinary incontinence and failure to conceive, along with other significant constitutional symptoms*** will usually narrow the differential diagnosis

- History: a summary of the history: bio data, parity and chief complaints/duration PLUS any other important symptom(s)

Gynecology Examination: Environment, client comfort /rights/respect/dignity: gowns / drapes: clean / large; equipment: preferably disposable; assistant / chaperone/ companionship; pelvic examination & heightened anxiety and is done last;

General Examination: general appearance, posture, nutritional status, respiratory distress, pallor, jaundice, lymphadenopathy, oedema, **VITAL SIGNS**

Abdominal exam

Physical Examination of the Abdomen

Inspection

Palpation

Percussion

Auscultation

Inspection: Abdominal distention

- Global abdominal enlargement is usually caused by air or fluid or fat or fetus or fibroid or feaces, or pseudocyesis
- Localized enlargement probably mass

Palpation

- Abdominal examination

Abdominal Palpation

Technique

- Light
- Deep
- Liver edge

- Spleen tip
- Kidneys
- Masses

Abdominal palpation

- To palpate four quadrants superficially from LLQ counterclockwise: depends on the location of pain

Palpation (light)

- Areas of pain are reserved for evaluation at the end of the exam; areas of tenderness: **AT ALL TIMES LOOK AT THE PATIENT'S FACIAL EXPRESSION**
- Tenderness is a physical exam finding a reflex occurs (muscle splinting, wide eyes, moaning, teeth gritting).
- Guarding, rebound tenderness

Palpation (deep)

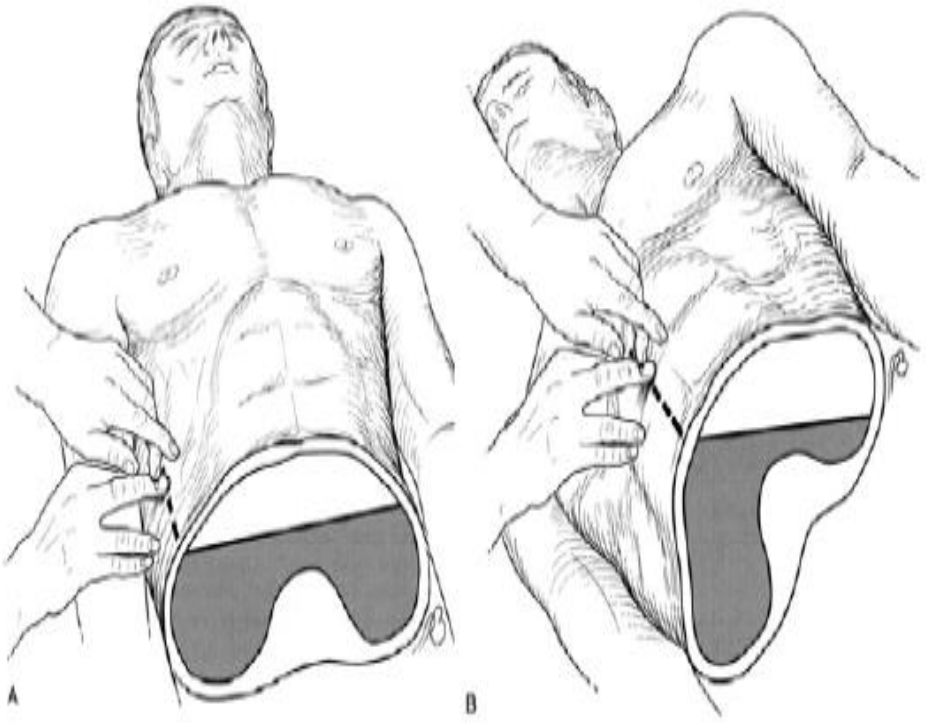
- Entire palm
- Either one- or two handed technique is acceptable
- One hand technique: Use palmar surface of fingers of one hand and a deep, firm, gentle maneuver to examine abdomen

Abdominal Exam -Percussion

- More valuable than palpation in the diagnosis of a tumour and distinguishing it from ascitis
- Areas of dullness for tumours (without an adherent loop of the bowel), liver, spleen, kidneys
- Shifting dullness for ascitis
- Resonance for the bowel
- Intraperitoneal tumor- dull to percussion, retroperitoneal tumour-resonant to percussion:WHY?

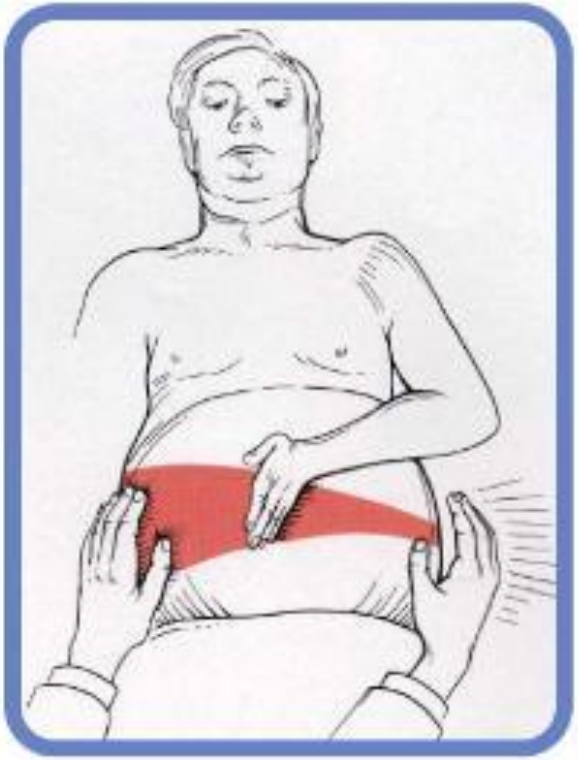
Shifting Dullness-ascitis

- Patient rolled slightly toward the examined side; movement of the dull point medially is described as “shifting dullness” and suggests ascites

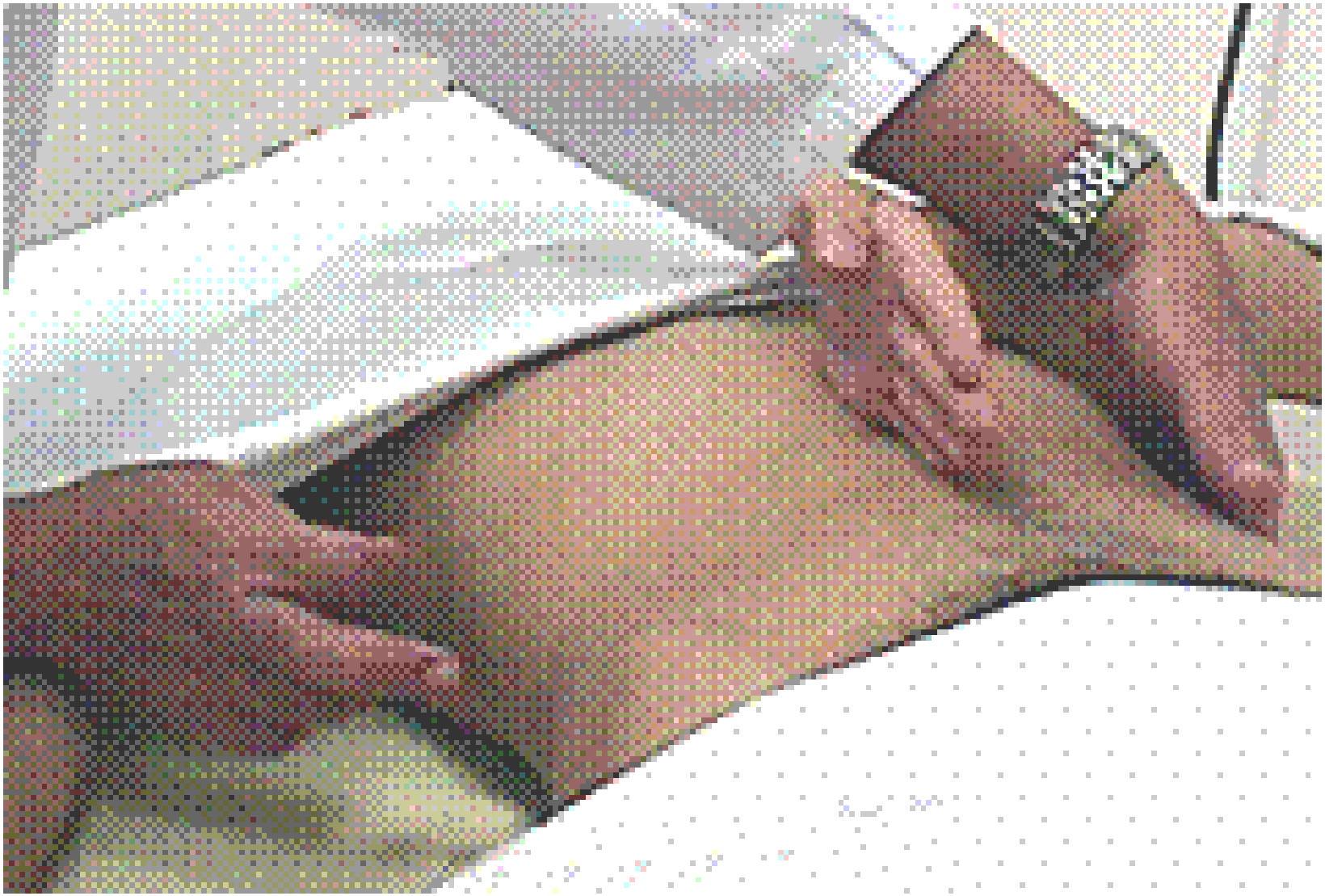


Fluid wave

- Only detected when a large amount of ascites is present.
- Requires an extra hand.
- A sharp tap with the fingers of one hand is followed after a slight delay by an impulse to the receiving hand.



Fluid thrill



Abdominal Exam-auscultation

- Auscultation for bowel sounds
  - Reduced or non existent: illeus, peritonitis
  - High pitched and increased: intestinal obstruction

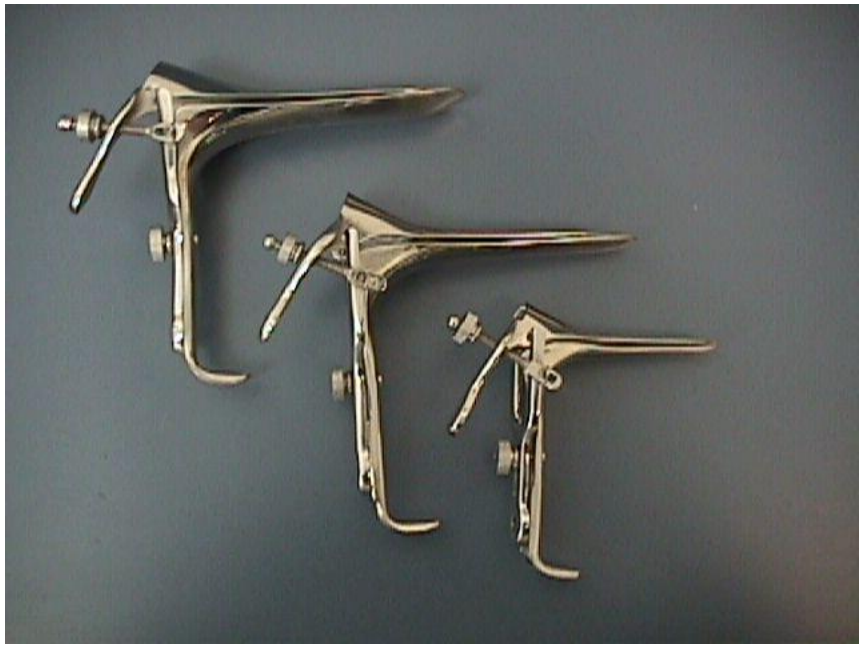
Pelvic Examination

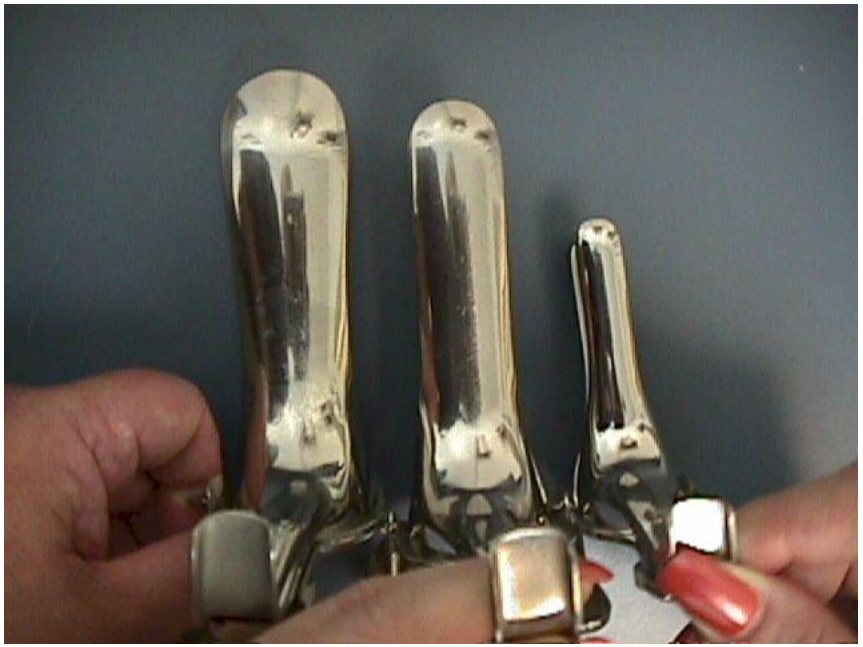
- Chaperone, consent, empty bladder/rectum, good light, privacy
- Infection prevention practices
- Hand wash, glove, warm vaginal speculum obtain specimens as needed (Pap smear, cultures)

Positioning/Inspection

- Drape-privacy: exposure and modesty; physical and psychological comfort
- Supine position, flexion at the hip and knee and abduction; lithotomy-legs in stirrups
- Hair distribution; vulval skin; look at the perineum for scars/tears, FGM;
- Gently part labia – inspect urethra, Bartholins gland
- Look for bleeding, discharge, prolapse, ulcers, warts, swellings

Vaginal speculums-Bivalve (cuscos)



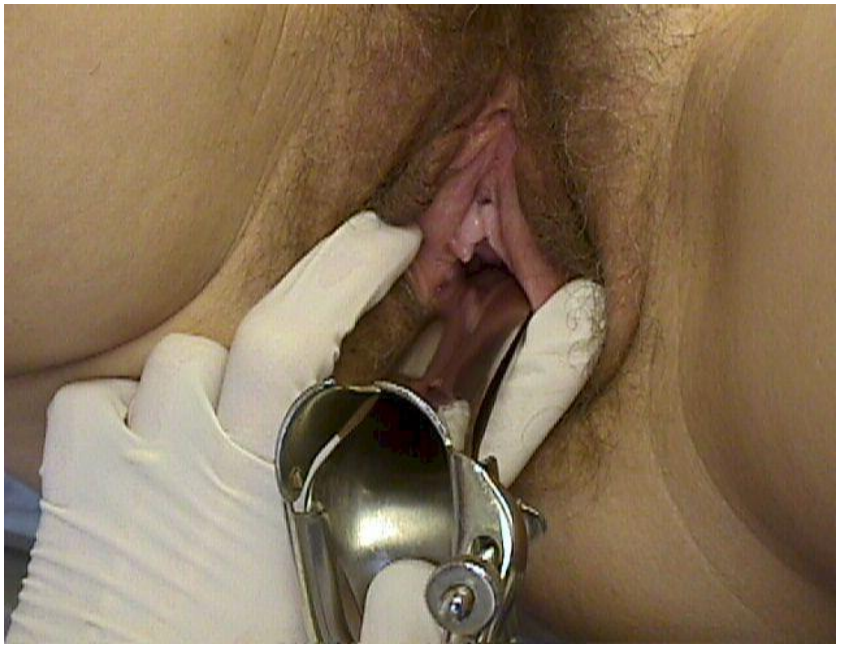


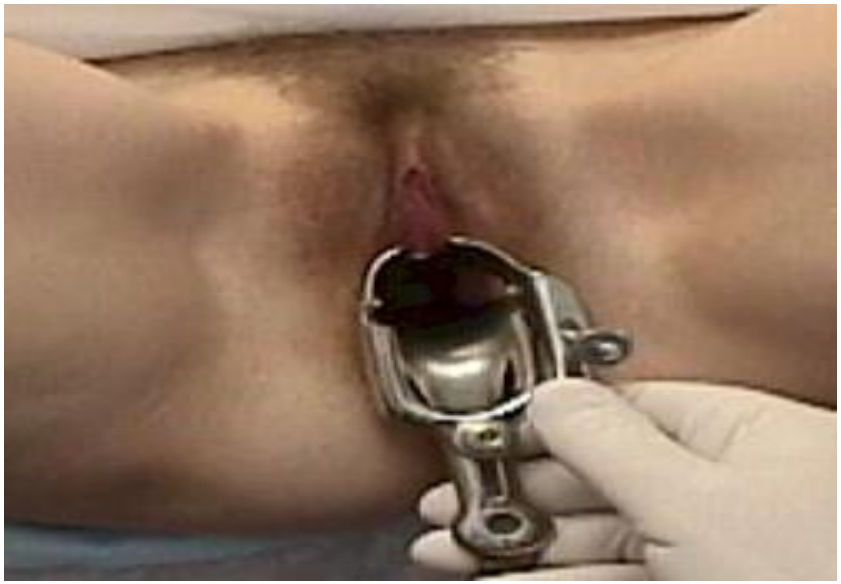
Two types of bivalve (Cuscos) speculums

- Thin blade: Pederson speculum
- Wide blade: Grave's

Vaginal speculums- Sims

Insertion of bivalve speculum





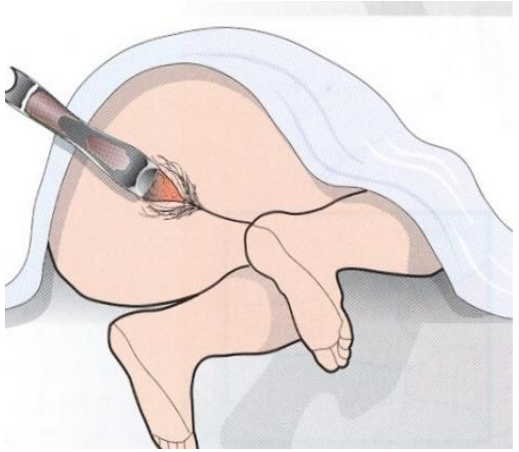
- Use lubricant
- Warm speculum
- Hold speculum in dominant hand
- Part labia with non-dominant hand
- Slowly insert
- Blades remain closed until fully inserted
- Visualize cervix (external os)

Inspection of Cervix/ vaginal wall

- **Inspect for:** discharge, warts, tumours, size of cervical os, bleeding, pin holed or fish mouth
- **Inspection of vaginal wall:** withdraw the speculum slowly observing the vaginal wall: inspect vaginal mucosa as the speculum is withdrawn; close blades as the speculum emerges from the introitus

Univalve Speculum Positioning

- Position patient in the left lateral position
- Left leg extended
- Right Knee drawn up to chest
- Hold back anterior vaginal wall with lubricated speculum



Perform a Bimanual Examination

- From a standing position, introduce the index finger and middle finger of your gloved hand into the vagina
- Exert pressure posteriorly
- Your thumb should be adducted with the ring finger and little finger into your palm to avoid touching the clitoris.

Perform a Bimanual Examination

- Palpate the vaginal walls as you insert your fingers for tenderness, cysts, nodules, masses or growths
- Identify the cervix, noting the following:
  - Position: anterior or posterior
  - Shape: pear-shaped
  - Consistency: firm or soft
  - Regularity
  - Mobility: move from side to side 1-2 cm in each direction
  - Tenderness

Perform a Bimanual Examination

- Palpate the fornix around the cervix
- Place your free hand on the patient's abdomen ± midway between the umbilicus (depending on size of pelvic mass) and symphysis pubis and press downward toward the pelvic hand

Bimanual exam-Uterus

- Size
- Shape
- Regularity
- Tenderness
- Position
- Mobility
- Masses

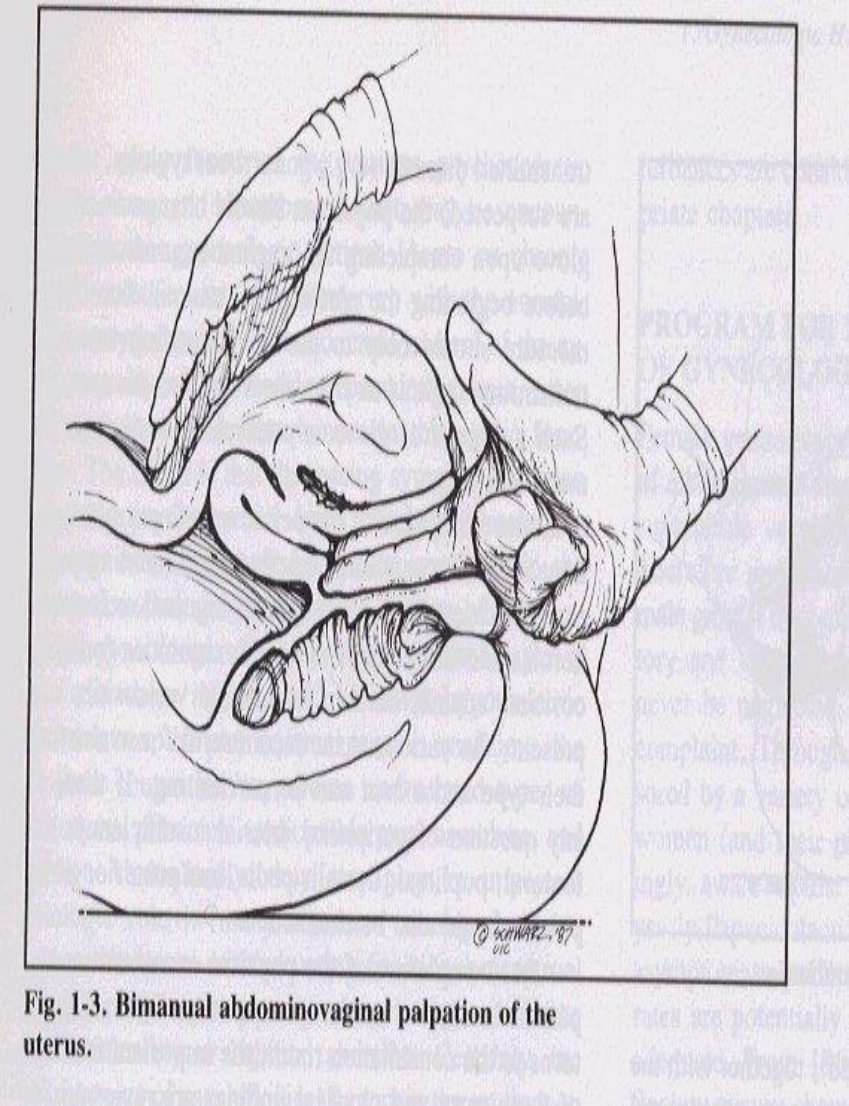


Fig. 1-3. Bimanual abdominovaginal palpation of the uterus.

Bimanual exam- Adnexia

- Masses
- Tenderness
- Ovaries
- Mobility

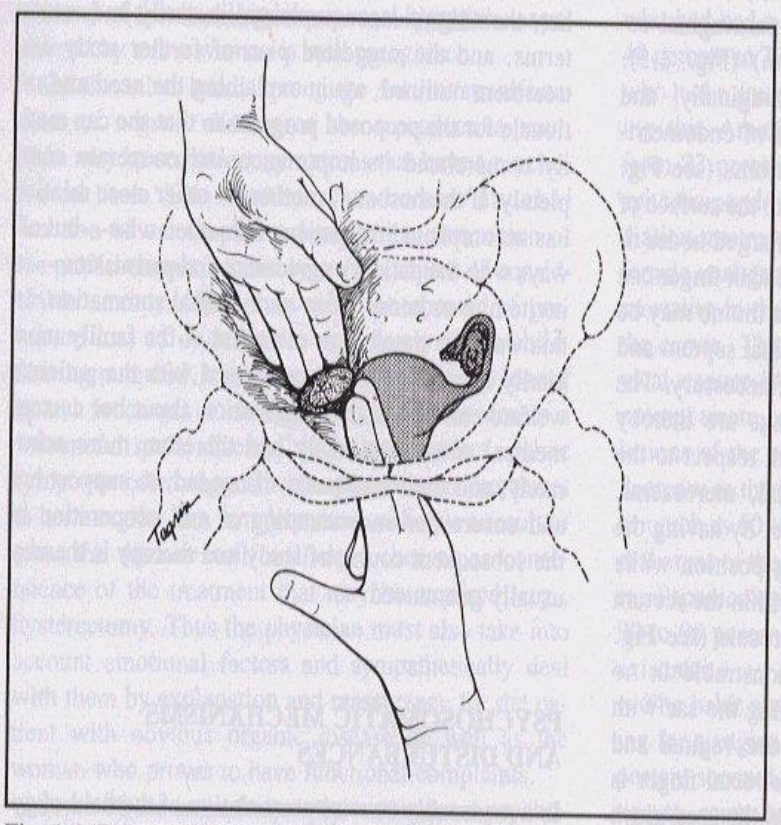


Fig. 1-4. Bimanual abdominovaginal palpation of the adnexa.

How do you differentiate uterine from adnexial mass on pelvic exam?

- Easy ☺
- Do a bimanual exam
  - With your fingers touching the cervix, move the uterus using the other hand in the suprapubic area
    - If the mass is uterine the cervix will move away from your fingers!

Recto-vaginal Examination

- The rectovaginal exam allows the examiner to reach almost 1 inch higher into the pelvis
- The rectovaginal exam is usually performed after the bimanual examination.
- Change gloves to avoid risk of spreading infection from vagina to rectum
- Lubricate dominant gloved hand
- Inspect the perianal area for lesions, discoloration, inflammation and hemorrhoids

Recto-vaginal Examination

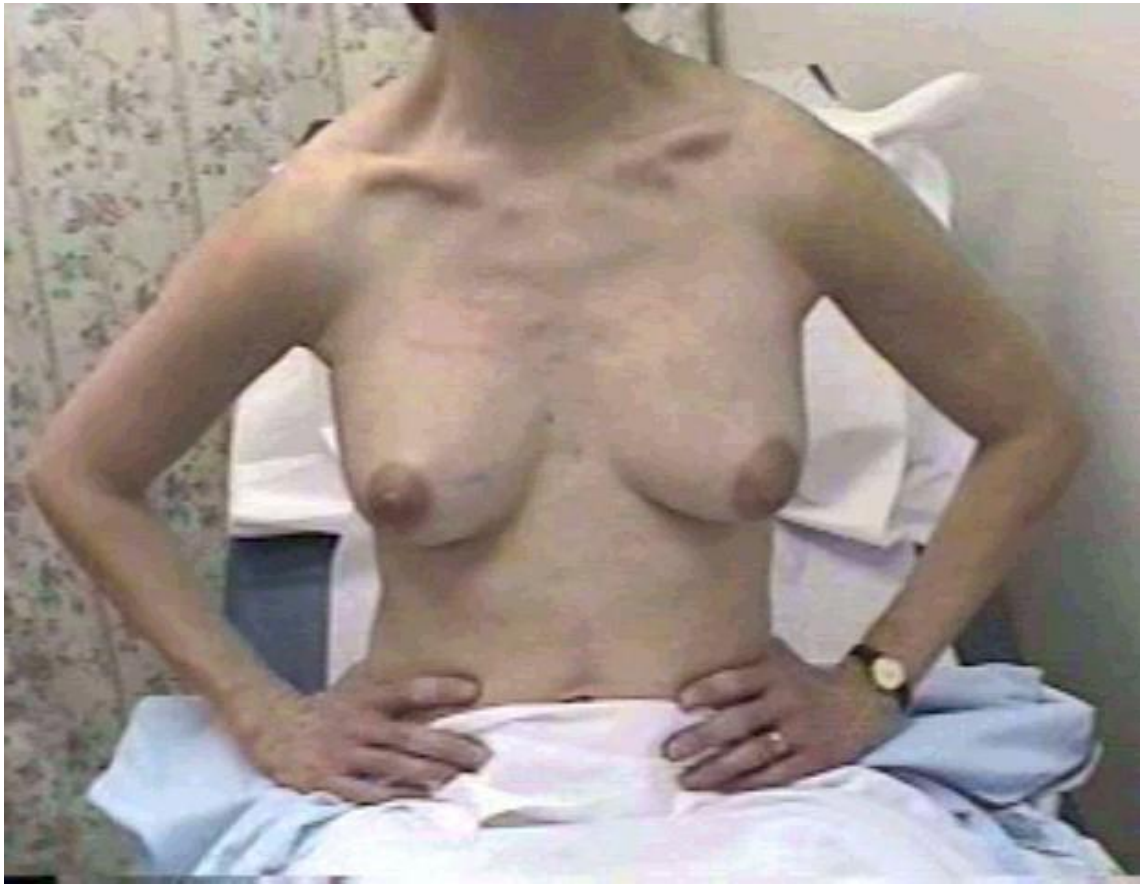
- Client is instructed to bear down as though she as having a bowel movement
- As the anal sphincter relaxes, insert your fingertip of the second finger gently into the anal canal and the 1st finger into the vagina, palpate:
  - Sphincter tone
  - Ano-rectal junction
  - Rectal wall
  - Masses
  - Tenderness
  - Bimanual exam

Breast Exam

- Inspect
- Palpate Axilla
- Palpate Breast
- Palpate Nipple

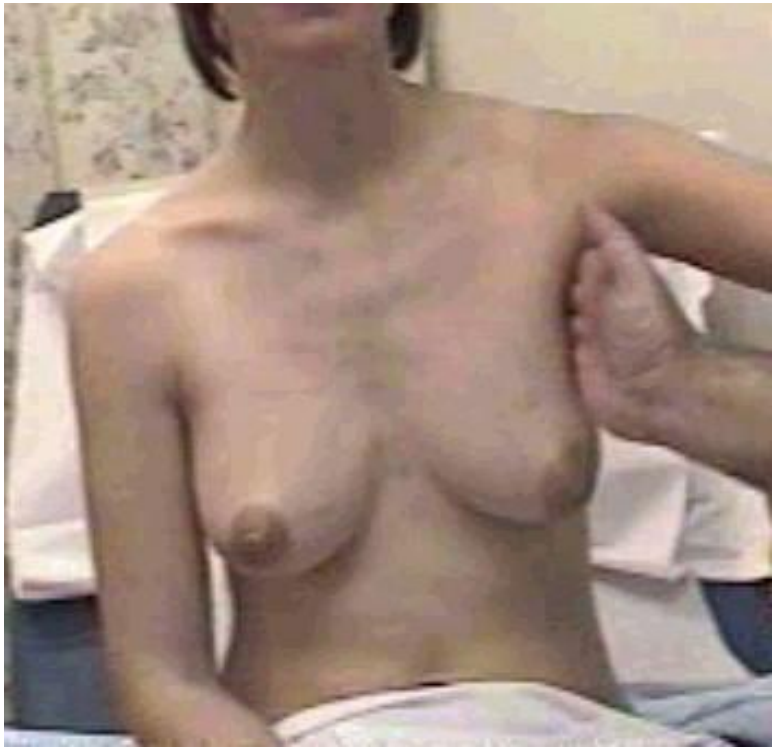
Sequence of breast exam

- Patient sitting or standing--press hands on hips to contract pectoral muscles (This maneuver accentuates any existing tissue retraction.)
- Observe size and contour and appearance of the skin
- Observe direction of nipples



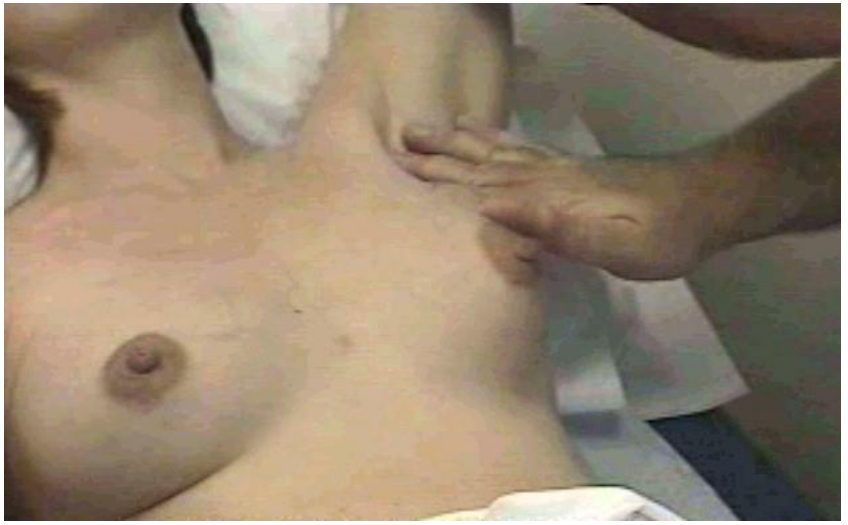
Sequence of Breast Exam

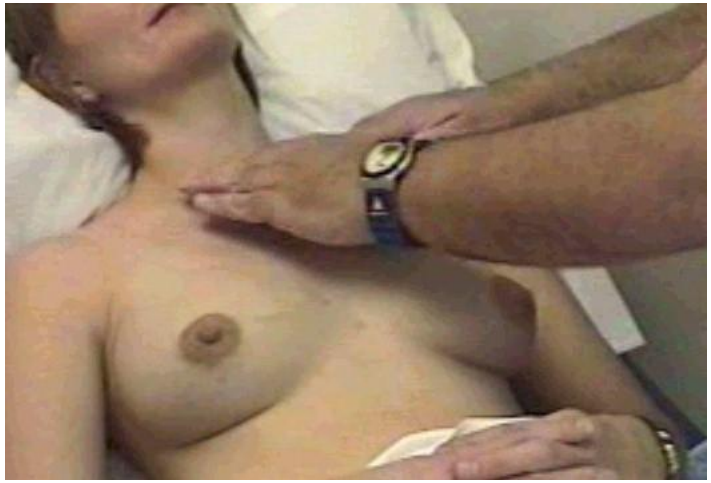
- Palpate axillary region

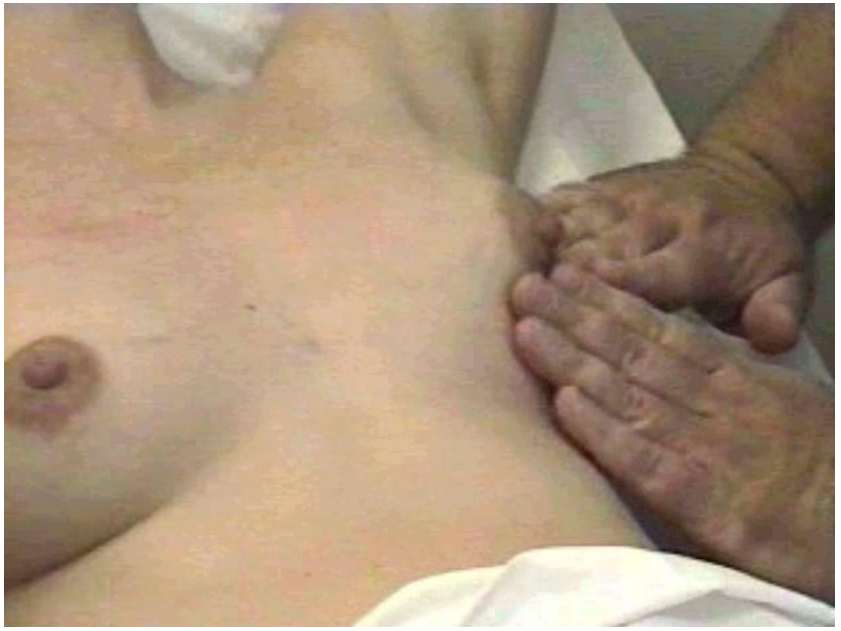


Sequence of Breast Exam

- Have patient lying flat with arm abducted and hand under head (This helps flatten breast tissue evenly over the chest wall.)
- Palpate entire breast and lymph nodes, (axillary and infraclavicular)
- Palpation is performed in a rotary motion using an organized approach

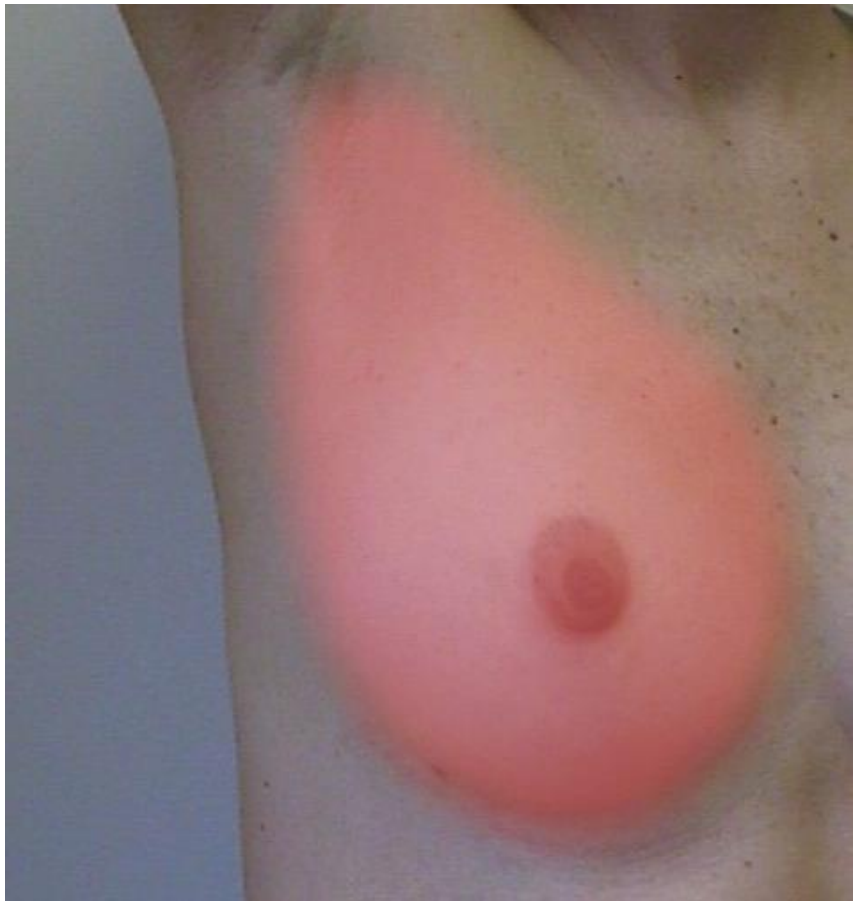






Sequence of Breast Exam

- Some examiners start in the upper outer quadrant where tumors develop most frequently
- Breasts of young clients are firm and elastic
- Older clients, the tissue may feel stringy and nodular.



Sequence of Breast Exam

- Palpating large pendulous breasts, use a bimanual technique. The inferior portion of the breast is supported in one hand while the other hand palpates breast tissue against the supporting hand
- Special attention is given to palpate the nipples, and areola
  - Entire surface is gently palpated
  - With thumb and index finger compress the nipple; note any discharge.

NOTE: If a client complains of a mass or tenderness of one breast, examine the opposite breast first to ensure an objective comparison of normal and abnormal tissue.

Examination of other systems

- Respiratory
- Central nervous system
- Muscular/skeletal system

Impression and Differential Diagnosis

Investigations

- Supportive
- Definitive (Specific)

Management

- Supportive
- Definitive (Specificic)

Sikomo